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ABSTRACT

In an effort to help practitioners deal with the great volume of current literature in the field of marriage and family therapy, this compilation attempts to present clinically relevant material in a user-friendly format. Topics selected for inclusion are believed to be up-to-date, informative, and clinically meaningful--as well as theoretically based and empirically grounded. The lessons included in this volume are: (1) "Counseling Children of Divorce" (Paul J. Ciborawski), which relates treatment strategies that evolved out of contemporary research findings; (2) "Family Diagnostic Testing, A Neglected Area of Expertise for the Family Psychologist" (Dennis A. Bagarozzi), which describes several scientifically developed instruments for assessing family systems; (3) "Understanding and Treating the Remarriage Family" (Florence W. Kaslow), which offers advice for clinicians working with reconstituted family systems; (4) "Working with Families Headed by Single Fathers" (Geoffrey L. Greif), a discussion of the practical and emotional concerns of single fathers; (5) "The Role of Family-Treatment Approaches in Adolescent Substance Abuse" (William H. Quinn), which stresses the intergenerational nature of substance abuse; and (6) "Parent Training for Children with Attention Deficit Hyperactivity Disorder" (Robert F. Newby), which stresses the importance of parent involvement in treating hyperactive children. Contains references at the end of each issue. (RB)

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1993

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DIRECTIONS IN MARRIAGE AND FAMILY THERAPY

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Directions in Marriage and Family Therapy

VOLUME 1

Introduction

Dennis A. Bagarozzi, PhD

Dr. Bagarozzi is in private practice in Atlanta, GA.

INTRODUCTION

There are more than a dozen professional journals published in the United States that are devoted specifically to the practice of marriage and family therapy. Trying to keep abreast of the latest clinical developments, training issues, theoretical refinements, and research findings—especially those that have practical value—is often difficult for the practitioner who has precious little time to carry out a systematic and thorough literature search for his or her clinical practice.

Directions in Marriage and Family Therapy (*DIMFT*) can help reduce this burden, because our continuing education series presents clinically relevant material to practitioners in a user-friendly format. Although it would be impossible to include in this series all relevant information found in the journals and professional publications we reviewed, we did attempt to select topics we believed to be up-to-date, informative, and clinically meaningful—as well as theoretically based and empirically grounded.

Accountability in marriage and family therapy has a long history; marriage and family therapists have always turned to empirical inquiry to evaluate their effectiveness. In fact, marriage and family interventions grew out of the early research that was designed to explore the dynamics of severely distressed marriages and family systems. It is in this tradition that *DIMFT* was conceived.

The primary goal of *DIMFT* is to enable marriage and family therapists to continue the practice of scientifically based intervention. Empirically guided practice enables therapists to work with clients using procedures that are as informed and as up-to-date as possible.

Lesson 1
Counseling Children of Divorce

An excellent example of treatment strategies that evolved out of contemporary research findings can be found in Dr. Ciborowski's lesson. In my own work with children of divorce, I have always treated divorce as a traumatic experience for them. The "sleeper effect" described by Dr. Ciborowski can be understood as one symptom of a post-traumatic stress response in these children. This delayed reaction should be expected to occur in children, especially if they are young and have not had the opportunity to progress through the various stages of grief reviewed in this lesson. Therapists who work with such children should be on the lookout for other post-traumatic stress responses that signify that the work of mourning has not been completed.

Denial, sleeper effects, acting up in school, and the like are some of the most commonly observed behaviors of children who are trying to deal with the trauma of divorce. Another less obvious but frequently observed means by which children gain some sense of control over their experience of the divorce (or other upsetting life events) is the continual orchestration and recreation of these tragic events unconsciously in their everyday lives. These events are often played out repeatedly (sometimes in highly disguised and symbolic ways) until some sense of mastery, resolution, or completion has been achieved. Turning a frightening event that was once experienced passively into a drama over which one now feels a sense of control is the basis for such repetitive behavior.

Sometimes, such unconsciously motivated behavioral themes become central to an individual's personal mythology; and these themes often persist into adult life. For example, I once treated a young woman whose father abandoned her and her mother when she was in grade school. When she became a teenager, she would frequently threaten to leave home whenever she and her mother had a serious disagreement. This identification with her abandoning father was so strong and so central to her own identity that she would regularly abandon boyfriends whenever she began to feel dependent upon them. She "walked out" of two marriages and was thinking of abandoning her current husband when she consulted me. Understanding this complex dynamic can be very helpful in working with children of divorce—no matter how old they are.

Lesson 2
Family Diagnostic Testing: A Neglected Area of Expertise for the Family Psychologist

Cost containment, quality of services rendered, and effectiveness of outcome—that is, accountability—is becoming a major consideration of the profession, especially in situations with third-party payers. One way for family therapists to demonstrate their clinical effectiveness is to conduct pretreatment diagnostic assessments, post-treatment outcome evaluations, and follow-ups as a routine part of their practice.

Lesson 2 of this series describes several scientifically developed instruments of demonstrated reliability and validity that I have found to be extremely useful in demonstrating accountability. Because many of the instruments and procedures employed in family diagnostic testing were designed to assess systems variables, these tests can be used to evaluate the functioning of a variety of family systems. Many of the measures used in family evaluation are clinical instruments that were designed specifically to capture change, and are well suited for pretreatment, post-treatment, and follow-up assessments.

More rigorous attempts by the profession to demonstrate accountability will also influence therapist training and education (including continuing education). In this scenario, graduate training programs would be expected to produce scientific practitioners who are capable of objectively evaluating the effectiveness of their therapeutic endeavors. Practicing clinicians who received no training in empirically based diagnostic testing and outcome evaluation might be required to enroll in continuing education programs specifically designed to help them develop the skills needed to conduct objective pretreatment assessments, post-treatment evaluations, and follow-ups as a prerequisite for professional license renewal and certification.

Lesson 3
Understanding and Treating the Remarriage Family

Work with remarried family systems has become routine for most family therapists. Some sociological research has shown that divorced persons are more likely to end unsatisfactory marriages than those involved in a first marriage. Therefore, the commitment to working through marital and family problems may be quite different for previously married spouses than for first-time couple/family systems.

Dr. Kaslow's lesson offers excellent advice for all clinicians who work with reconstituted family systems. A few ideas that the family therapist should consider when working with reconstituted families include:

- How might a marriage/family therapist help increase a remarried spouse's level of commitment to the marriage so that intervention can be more effective?
- In what way should premarital counseling programs for remarried persons differ from premarital counseling approaches used with those who are marrying for the first time?

Although models that outline the unique developmental tasks of remarried families do exist, they have not, as of this writing, been empirically validated. It is my hope that research into this very important and complex issue will unearth such data in the near future; the findings from such investigations will be invaluable for practicing therapists.

Lesson 4
Working with Families Headed by Single Fathers

As is true of many clinicians, my work with single-parent fathers is limited, but I have found it to be extremely rewarding. All the men I worked with were determined to be good fathers, but what this meant was unclear to them. Some said they did not want to be like their own fathers. Others said they knew nothing about raising girls. In most cases, these men required very specific information about child development as well as guidelines and instructions for behavior management. Dr. Greif provides very practical, concrete suggestions for managing day-to-day concerns such as housework, the father's career, and dealing with emotional issues.

In all cases when single-parent fathers have come to me for help, they were delighted to be able to work with another man, particularly one who had raised two children of his own. Talking "man to man" with another father did not engender the feelings of inadequacy that many of them had experienced when they sought help from female therapists, guidance counselors, teachers, etc.

Of course, I do not mean to imply that female therapists should not work with single-parent fathers or that female therapists are not competent to deal with the issues these men present. Rather, women who do have the opportunity to work with single-parent fathers should be sensitive to the possibility that the father may be uncomfortable with her; and it is best to deal with this issue in a straightforward, objective manner. Bringing in a male cotherapist in such cases may be helpful during the initial phase of treatment or until the father has developed a trusting relationship with the female therapist.

The most difficult undertaking for many of the men I worked with was learning how to use child management techniques that were nonphysical or coercive in nature; the majority of these fathers had themselves been physically punished as children, and needed to learn more effective means of discipline. I found group training sessions extremely helpful for these fathers. As increasing numbers of men obtain custody of their children, I suspect that we shall see an increase in such educationally based men's parenting groups.

Lesson 5
The Role of Family-Treatment Approaches in Adolescent Substance Abuse

In some sectors of society, drug abuse and its accompanying violence have reached epidemic proportions. In some subcultures, the traditional family has been fragmented beyond recognition. In such situations, the violent street gang often serves as a substitute for the family. Like traditional families, the gang has its own rules, codes of dress and conduct, and regulations governing interpersonal interaction. It has its hierarchy, its values, its rituals, and its traditions—as well as its myths. Older members socialize the younger recruits into the gang culture, and senior gang members serve as models for adult behavior. The "gang family" affords each youngster an opportunity to develop his or her unique identity and provides younger members with a sense of purpose, protection, belonging, and security in a very uncertain and unstable world.

The challenge for family practitioners who choose to work in such subcultural settings is to help rebuild a family-based community structure. I truly believe any attempt to solve this problem that targets only the individual substance abuser while neglecting the social network in which the abuser lives will be doomed to failure. Dr. Quinn's lesson underscores the importance of the therapist understanding the intergenerational nature of substance abuse.

In my own work, I have found it extremely helpful to include substance abusers from past generations when treating adolescent drug addicts and alcoholics; even when this is not physically possible, it is important to gather intergenerational histories (using a genogram or some other intergenerational assessment instrument) before beginning formal intervention. Whenever members of previous generations are available for interviews, they should be brought into the therapeutic process.

One of the most interesting aspects of Dr. Quinn's lesson is his diagrammatic model of family therapy, which breaks down the intervention process into three separate stages. For each consecutive stage, Dr. Quinn identifies family systems and contextual goals. He then describes the strategic behaviors the therapist should exhibit in order to achieve these goals. Here again, we see how the courses offered in this continuing education program offer pragmatic information that therapists can use to guide their practice endeavors.

Lesson 6
Parent Training for Children with Attention Deficit Hyperactivity Disorder

Dr. Newby's lesson points out what every clinician who works with children diagnosed with attention deficit hyperactivity disorder (ADHD) knows—parent training and parent involvement are essential if the child's problem behaviors are to be reduced. Behavioral and cognitive behavioral interventions are the treatment of choice for such conditions.

In my clinical work with ADHD children and their families, I have frequently found that one or both parents evidence a number of the same symptoms characteristic of their children—for example, restlessness, low frustration tolerance, distractibility, impatience, short attention span, need for immediate gratification, and sensation seeking. Frequently, such parents are unable to continue implementing behavior modification programs with their ADHD children, because they find it difficult to "stick with the program" and because they expect immediate, drastic results after only a few therapy sessions. The absence of such immediate gratification often causes them to lose interest. Many parents subsequently revert to using physical punishment with their children, because it appears to bring about immediate results and also serves as a tension release for the parents. Unfortunately, it also compounds the problem. Clinicians working with such families should be aware of this dynamic when designing an intervention program for ADHD children.

For more than a decade, the field of marriage and family therapy was preoccupied with strategic approaches to intervention while more mundane treatments, such as parent training, received little attention. Teaching parents how to collect baseline data, apply contingencies correctly, and monitor treatment is certainly not as exciting as formulating a paradoxical intervention. However, this is what is required in work with ADHD children and their parents. Dr. Newby's lesson brings us all down to earth by reminding us that family therapy is often blood, sweat, and tears—hard work indeed!

* * *

We at *DIMFT* are pleased to bring you this continuing education program, and we sincerely hope that the lessons published herein will provide you with helpful information for your clinical work with distressed marriages and family systems. I welcome your comments, insights, and suggestions for change. Likewise, please let us know if there are any particular topics or issues that you would like us to cover in future volumes. Again, thank you for using *DIMFT* as a resource in your professional development.

—Dennis A. Bagarozzi, PhD
Atlanta, GA
October, 1993

Directions in Marriage and Family Therapy

VOLUME 1 • LESSON 1

Counseling Children of Divorce

Paul J. Ciborowski, PhD

Dr. Ciborowski is Associate Professor of Counseling, Long Island University,
C.W. Post Campus, Brookville, NY, and Chair of the Brookhaven [NY] Youth Board.

VOL. 1

NO. 1

KEY POINTS

- Approximately 12 million American children have been affected by the experience of divorce. Negative reactions to divorce can manifest themselves in children; examples include absenteeism from school, unwanted pregnancies, substance abuse, academic and social underachievement, depression, and suicide.

- The first 3 years after divorce are the most critical for children. Behavioral problems may develop during this period. A "delayed reaction" to divorce is also possible, especially in boys.

- Therapists should be aware of changes in child-custody laws. Older children should be involved in their own custody decisions—the rights of the child should be heard.

- Kübler-Ross' four stage model for coping with difficult emotional events may be applied to children's experiences of divorce: denial, anger, guilt, depression, and acceptance. The four-stage cycle can take 2–3 years to complete, and even longer if the parents remarry.

- Feelings and their therapeutic interventions:

  Denial—Do not confront directly. Bibliotherapy and play therapy are recommended. Parents must give children reassurance.

  Grief—Can be healthy. The therapist should react with empathy to child's grief, encouraging its expression.

  Guilt—The strength of guilt is in its irrationality. The parents' role is crucial: to explain the reasons for the divorce. Unaddressed guilt may lead to phobias, fears, and compulsions in later life.

  Anger—If repressed, anger can be very dangerous. The therapist should encourage direct expressions of anger by the child to the parent. Role reversal and role play can be useful. Once the source of anger is discovered, parents and children can negotiate compromises in the family-therapy setting.

  Fear of Abandonment—Rational explanation will not allay fears—behavioral techniques include a rewards system for dealing with time spent apart from parents. These techniques, reinforced by counseling, should prevent long-term feelings of loneliness.

  Sadness and Depression—Allow the child to grieve and express feelings. Family therapy, in addition to individual counseling, may be useful. Be sensitive to physical as well as emotional/behavioral signs of depression.

Introduction

Young people encounter many crises, including divorce; in the United States, **12 million children have experienced divorce in their families** (Carlile, 1991) and show its strains. Being involved in a divorce may have many **side effects** for young people, including increased **absenteeism** from school, **running away** from home, drug abuse, **unwanted pregnancies**, childhood **depression**, **underachievement** in school, and **suicidal thoughts** (Ciborowski, 1984; Doherty & Needle, 1991; Neighbors, Forehand, & Armistead, 1992; Wallerstein & Kelly, 1991).

The past decade has produced an abundance of literature concerning the effects of divorce on children. This lesson summarizes several of the latest findings. For more detailed information, the reader may consult the references and suggested reading at the end of the lesson.

In my experience as a practicing therapist, divorce produces no winners. However, if there are any losers, they are the children. **The parents may be overly concerned about their own interpersonal difficulties and divorce negotiations, thereby forgetting that their children are active participants in the divorce.** However, the concern for children and their welfare becomes important when behavioral problems develop. **Although young people are full participants in a divorce, they are rarely consulted or given adequate warning of what to expect.**

The goals of this lesson are to provide mental health professionals with relevant psychological information concerning children of divorce; describe typical feelings experienced by these children; and discuss counseling techniques that may be effective in helping youngsters process their feelings.

Critical Years for Children

Evidence indicates that **the first 3 years after a divorce are the most critical for children** (Francke, 1983). During this time, **behavioral problems** may become evident. For example, some young people may experience a significant **drop in school grades**. In one such instance, a student achieved solid marks through the 8th grade and underachieved through 9th and 10th grades while his parents were getting a divorce and battling over custody. Only in the 11th grade did he start to put his academic and emotional life together (Ciborowski, 1988).

Many other problems experienced by children today (e.g., **drug use, suicide,** and **dropping out of school**) start with parental separation and divorce. Suicides among young people (ages 15–24) have tripled in the past two decades. During this same period, divorces reached 1 million per year. **The loss of a parent—so typical in divorce—was found to be a very strong determinant in many suicide attempts by adolescents** (Ciborowski, 1984).

Some groups of children do not show immediate changes after a divorce. However, for these youngsters, there is often a **"sleeper effect"** at work; 2 or 3 years later, well within the "3-year rule," there may be a **delayed reaction.** In working with groups of boys, for example, I have frequently noted this effect (Ciborowski, 1984). **After initial denial to the therapist that "nothing's changed," adjustment difficulties are acknowledged. They may be caused by financial pressures on the single-parent family or the personal and social problems created by a move to a different neighborhood, a new school, or the effort to find new friends. Boys seem to have a higher incidence of the "sleeper effect" than girls** (Wallerstein & Kelly, 1980).

Who Is the Custodial Parent?

Although fathers have become more active in seeking custody of their children, statistics show that **90% of the time, the mother becomes the custodial parent** (Ciborowski, 1988). Mental health professionals are more likely to be working with a single-parent family headed by a mother. There may or may not be active paternal involvement.

The decision concerning which parent should be granted custody of the children after a divorce always has been a reflection of cultural and historical attitudes. So far in the 1990s, the mother is usually awarded child custody in the majority of cases. Yet this has not always been so. Up until the early 1900s, the father was the custodian of choice for most children. Men, in general, were assumed to be the more stable parent. This belief reflected the strong "promale" bias of 19th-century jurisprudence (Chesler, 1985). However, this has changed with an enhanced judicial appreciation of the role of the mother in child development.

Judges generally examine each parent to determine which one is more capable of supporting and raising a child. In cases where custody is disputed, **the father is given custody more often**. In addition, **joint custody is also an option.** [Please see the glossary for an explanation of custody terms.] **Therapists must keep abreast of the fast-moving decisions being made in the legal arena** (Lowery & Settle, 1985).

Custody cases should involve older children. Judges may grant children standing in court so that their rights are represented in custody hearings. One case, the "Gregory K" case in Florida, set a new precedent. Gregory, although underage, was allowed to petition the court to be allowed to live with his foster parents. In granting the petition, the court overruled the request of his natural mother (Rohter, 1992). Therapists should be very sensitive to this issue: **The rights of the child must be heard**. As prochild advocates, therapists have no other choice (Pearson & Thoenness, 1990).

Children's Feelings After a Divorce

> *Mike, age 15, was frequently absent from school. His grades during the first half of the year dropped 10–15 points in every major subject. Each teacher had similar comments on his report card: "inattentive," "does not do homework," and "is not prepared." Also, Mike had been involved in a number of fights with classmates and had been insubordinate to teachers and administrators.*

Though Mike was in need of counseling, **the therapist may not necessarily relate Mike's problems to divorce. He may appear no different from other teenagers with adjustment problems in school; however, the divorce is a wrenching trauma that sets him apart**. The impact of his parents' divorce and the time needed for readjustment are both painful and disruptive. Mike's academic record and disruptive school behavior only hint at the powerful undercurrents at work.

Psychological Stages

As witnesses to their parents' divorce, **children may experience many conflicting feelings. In addition to the initial shock and surprise are denial, grief, fear, guilt, and anger**. To understand these feelings better, it is useful to employ a model originally designed for use with terminally ill cancer patients. Developed by Dr. Elisabeth Kübler-Ross (1974), the **stages model places feelings about death within an understandable pattern**.

Adapting this model for the child of divorce, **the first "feeling" stage is one of denial. The child does not want to, or simply cannot, accept the reality that a breakup is occurring. The second stage involves feelings of anger, resentment, or guilt. Acting-out behavior is fairly common during this stage. The third stage is depression, which usually occurs when the young person realizes that he or she cannot change the situation or immediately reunite his or her parents. The final stage is acceptance**. This comes about only gradually. **It occurs when a child realizes certain things cannot be changed and he or she perceives some positive aspects to the divorce** (e.g., no more parental fighting at home and/or the fact that there can still be a relationship with both parents in spite of the divorce (Sonnenshein-Schneider & Baird, 1980). The stages may cover **2 or 3 years, and if there are other subsequent life-transition events** (such as a parental remarriage), **the cycle may be repeated**.

In observing this cycle, it becomes apparent that **children are more than observers during a parental divorce**. Because they are, in fact, full participants, they should be told the truth by both parents. **Teens, especially, should be involved in planning their postdivorce future, including custody**. However, more than 80% of children are not told in advance that a divorce is pending (Francke, 1983).

Denial

As mentioned above, denial is usually the first reaction experienced. **Denial is used by children to protect themselves from mental anguish**. No child does this deliberately; it is an unconscious process.

In fact, it is not always easy to detect denial. One child may react to a separation with a great deal of calm; and parents may be surprised at the ease of acceptance. Only later may the child ask, "When is Dad [or Mom] coming back?" Telling the child that Dad or Mom will not return seems to make no impression, and the child continues to await his or her return.

Denial occurs most often in younger children, who may fantasize that they will spend time with their father or mother in the evening and make excuses when he or she is not there. A young girl may pretend that "Mommy leaves for work before I get up in the morning and gets home after I fall asleep."

THERAPEUTIC INTERVENTION:

How can therapists intervene with denial? First, **denial is not completely negative. It serves as a protective buffer between self and reality**, and **should not be stripped away suddenly**. **Direct confrontation is also not advisable**; it may cause more anxiety and create further maladjustment.

A more useful approach is to talk with the child about a "make-believe family" in which a divorce or separation has occurred. The child can be asked to add to the story, which helps children discuss their own fears. **Talking about important feelings that other families are experiencing prevents anxiety**. **Bibliotherapy** (the use of books in counseling) **also may be helpful.**

Furthermore, therapists should communicate with parents; **they should remind them to reassure their children continually that they will not be deprived of care, food, clothing, or shelter**. This reassurance, in addition to therapy, gradually will help them accept the reality of the divorce.

Grief

Grief is another very common reaction to divorce. Although a parent is not actually lost, **the child's perception may be that he or she may never see or live with**

that parent again. Grieving sometimes can be healthy. Children who are old enough to understand what is going on should, in fact, grieve over the loss. However, one exception is in a family where there is so much turmoil that a separation is welcomed with a sigh of relief.

THERAPEUTIC INTERVENTION:

A therapist's compassionate reaction to the child's crying, remorse, or regret enables the child to realize that it is acceptable to react in this way. Therapists should *never* discourage the expression of such feelings, especially by comments such as, "Big boys and girls don't cry" or, "Be strong." Such comments are inappropriate and simply prolong the grieving process. Youngsters need to express their feelings in a protected environment, which therapists can (and should) provide.

Guilt

A third major reaction is guilt. **Young people frequently accuse themselves of having caused the divorce**, with the reaction that "I am a terrible person for what I have done." Children are very rarely the cause of a divorce, yet they may feel precisely that way if, for example, they heard their parents argue over money spent on them or about their disruptive behavior. **These guilty feelings often have no basis in reality**. One example is a boy who firmly believed he was the cause of his parents' divorce. Frank was 10 years old when he described an incident that sparked his feelings of guilt:

> *Frank had come home from school, gone to his room to change his clothes, and went outside to play with his friends. When Frank's father came home from work, he found that Frank had not returned the empty garbage cans to the garage. "Why don't you do what you are told, Frank?" asked his father, who then shouted, "Now, bring those cans into the garage and go upstairs to your room for the rest of the day!" Frank did as he was told and then went upstairs. The next day, he went to school, as usual, came home, and went upstairs to do his homework.*
>
> *That evening when Frank came down for supper, he noticed that his father wasn't there. "He's not coming back soon, Frank," his mother said. "Dad is going to be living on his own for awhile." With that, she discouraged any further talk on the subject. Frank soon found out that his parents were getting a divorce. As a consequence, he thought: "If only I had returned the garbage cans to the garage, Dad would not have gotten angry at me. He would not have left."*

THERAPEUTIC INTERVENTION:

Helping a young person work through his or her guilty feelings can be one of the most difficult tasks for therapists. Guilt can cling to one's psyche and resist the usual cognitive techniques. Its strength is in its irrationality.

Parental assistance can be very helpful in diminishing and eliminating feelings of guilt. As a start, there should be a **clear explanation by the parent(s) as to why the divorce occurred**. Acting as a facilitator, **the therapist should try to make it very clear that the divorce is not the fault of the child**. Within the context of family therapy, the child should start to realize the more complex reasons for the divorce decision. Furthermore, **time and patience** are also needed. Because guilt is felt particularly by younger children, **it can be outgrown if insight and understanding grow as well**. If not, guilt can fester and develop into the most unlikely phobias and compulsions.

Anger

Anger is another common feeling. Children of divorce must deal with many frustrating experiences that are **sources of anger**: **the conflict between their parents**; **physical changes** (new friends, school, or neighborhood); and **emotional tensions** (less money, a working mother, and Dad not taking them for a visit when he promised).

Anger can be hidden or displayed. When anger is repressed it can be extremely dangerous. Rather than releasing the feeling in a healthy way, children may keep it bottled up: "My anger was eating me up," said a 16-year-old girl. "It was making me claustrophobic. I wanted to feel free and all I felt was anger toward both my parents. It was all inside me." **Most of the time, this "bottling up" is done unconsciously. When upset by a parent's actions, for example, children simply will excuse the behavior rather than express their anger toward the parent**.

> *Elaine, age 10, waited dutifully by the door of her house for her father. He promised to pick her up on Friday evening at 7:00 PM for a weekend visit. He never came. Elaine told her therapist: "I'm not really bothered by it. I know Dad is very busy at work. He didn't have time to call me or to take me for the weekend."*

Is inhibited anger wrong? Not always. Each of us meets with frustrating situations every day. We cannot always express our anger. We have to think of the effect it will have on ourselves or others. Thus, we bring it under control.

THERAPEUTIC INTERVENTION:

Therapists do not want children to express anger in unhealthy ways. For example, many children become very tense—and stay that way. They are more irritable, cry easily, and even develop nervous tics (blinking, twitching, or other uncontrolled muscle movements).

When working with someone like Elaine, the therapist should **assist her in eventually admitting her feelings of anger and then being able to discuss them *directly* with her father**. The use of a **role-playing technique** would help the child verbalize her angry feelings. The therapist could play the father and Elaine could play herself, or the roles could be reversed.

However, **often a youngster may be angry about things that cannot be resolved**. A child may be upset, for example, by a custodial mother's work, which takes her away from the child. **Therapists faced with this situation should help reduce the child's anger by discussing alternatives with both parent and child**. For example, it could be suggested that they spend more time together doing something special during the week or on the weekend to make up for the parent's absence. Or perhaps the baby-sitting arrangements could be changed, and the child could play at a friend's house some days after school while the parent is working. **By exploring alternatives in a family-therapy setting, the therapist can defuse the child's anger**. This counseling technique can be applied to many other situations, such as parental dating, a new home, or disappointments during a noncustodial parent's visit.

Fear of Abandonment

Feelings of abandonment are particularly prevalent among younger children. They firmly believe that both the noncustodial and custodial parent are leaving them forever. These fears are understandable. Remember that **for a child, parents represent security. When this security is shattered by divorce, insecure feelings can be very strong**. Very young children may regress in behavior by sucking a thumb, wanting to sleep in the parent's bed, or wetting the bed.

In one case, a parent was particularly frustrated by her 8-year-old daughter's fears. "I kept reassuring her that I would not leave like her father. This didn't seem to help. All it did was make her worry that I, too, would leave." **An insecure child will cling vigorously to a parent or teacher**. One teacher related a story about a 7-year-old boy who took a can of soup to bed with him each night because he was afraid that his mother would leave home and he would have nothing to eat.

Fears of abandonment usually recede with time. As children live each day with one parent and visit the other parent, the fear diminishes. It becomes obvious to the children that although Dad and Mom are no longer living with each other, they still love them. However, in some cases, there *is* actual abandonment and one parent leaves entirely; in this case, the abandonment is real and cannot be easily explained away.

THERAPEUTIC INTERVENTION:

Therapists must allow children to talk through their feelings of being left alone. **Trying to explain rationally that this will not happen is *not* a fruitful counseling technique**. More effective is the therapist's **acknowledgment of the fear and suggestions to eliminate it**. In a family-therapy session, behavioral techniques can be suggested if the child experiences anxiety when the parent leaves the house and the youngster is left alone or with a baby-sitter. Such a parent could reward a youngster with a special treat for remaining in the home alone. The amount of time a child is left alone (or with a baby-sitter) could be extended gradually. **This behavioral technique, reinforced by counseling, should help to effectuate change so that loneliness does not become a problem in adulthood** (Murphy, 1991).

Sadness and Depression

For a time after a divorce, most children become sad. **This sadness, when severe, can lead to depression** (Hoyt, Cowen, Pedro-Carroll, & Alpert-Gillis, 1990). One way to detect that children are very sad is by their **inability to enjoy themselves**. **It is not useful to ask a child directly about their feelings toward a divorce**; he or she may respond by simply saying, "It doesn't bother me" or, "I'm fine and happy." However, a careful observer will notice **moodiness**. For example, a teacher would say, "Jeannie cries a lot in class" or, "She's not enthusiastic anymore. She just stays by herself during recess."

In many instances, children shake off this feeling and adjust to the reality of life after a divorce. They slowly regain enthusiasm for life, school, and extracurricular activities. However, **sadness can lead to depression if there is continuing turmoil in the house** (e.g., custody battles or financial arguments). It also could be prolonged by **unhealthy postdivorce difficulties, such as when a father or mother no longer visits the child, parents argue over child support, or children experience frequent moves to different neighborhoods.**

THERAPEUTIC INTERVENTION:

> *Soon after her parents divorced, 13-year-old Gail started therapy. She was living with her mother. Very soon after her father left the house, she stopped eating, lost interest in school, was very critical of herself, and became a loner. Gail's weight and physical appearance changed dramatically within a few months. Initially, Gail refused to admit she had a problem. Only later, as trust developed in the sessions, did she discuss her sadness. There was a custody battle in progress at the time, and Gail was very anxious about its outcome. With these pressures, she withdrew.*
>
> *Through family counseling, Gail's depression lifted. Her mother, who also suffered from bouts of depression, gradually was*

> *able to regain her own control. This, in addition to custody resolution, was a major factor in helping Gail overcome* her own *depression.*

Depression also can be linked to suicide. Therapists must be aware of the warning signs of suicide so that appropriate action can be taken. However, **if a child simply talks about his or her feelings, the type of build-up that leads to suicidal thoughts may be prevented. "Being there" for the young client is very much the key.**

The Desire to Reunite Parents

Any discussion of feelings would not be complete without mentioning one predominant feeling experienced by most children of divorce: **a desire to reunite their parents.** Reconciliation fantasies can be strong in children of all age groups but are more pronounced in younger ones. A child may say, "Please come back. I promise to be good!" Another attempt may be, "If you don't come back, I'm not going to school anymore."

Other children try to manipulate their parents to reunite. A 10-year-old boy once said to his mother, "Why can't we invite Dad to my birthday party on Saturday? He would love to come." In school, **a youngster could misbehave or earn low grades deliberately so that a parent-teacher conference would be necessary with *both* parents.**

The power of this feeling should not be underestimated. One graduate student described to her professor some very strong reconciliation feelings she was experiencing about her divorced mother and father; her parents had been divorced 12 years and she was 31 years old!

THERAPEUTIC INTERVENTION:

Although therapists should listen and provide support, **they should not attempt to attack this feeling directly as being irrational. Once children develop healthy coping skills, they can perceive themselves as successful. With this success, such feelings should diminish appreciably.**

Summary of Counseling Strategies

- Children should be encouraged to **talk through feelings of anger and guilt** and to do so in **an open and rational manner**. With reassurance and encouragement, therapists can discuss stressful issues with youngsters.
- **Encourage children to have outside activities** (e.g., sports, academics, community and school involvement) to channel their drives and feelings. An important concept involving an increase in the activity level is the **necessity of significant adults to "think small" and accept small gains.** If the activities chosen by the child are fun, the response will be more immediate and effective. **Involvement of the child in selecting and planning the activities will improve the likelihood of success.**
- **Try to help children develop relationships with strong adult role models,** who can be very helpful as they process their feelings about the divorce. Strong adult role models also can **provide the needed encouragement and positive reinforcement for their efforts.** Adult models must be patient and not discouraged when their efforts do not achieve immediate success.
- **The positive qualities of both the custodial and noncustodial parent should be emphasized.** Sometimes, involvement by an absent parent is not possible; however, **do not encourage negative feelings about such a parent.** Children also might benefit from a discussion about how the parents are separate individuals, each with a life of their own well before they met each other and married. In other words, they were men and women before they were parents. Their love for the child will continue whether or not they stay together.
- One specific technique to use with children is the **"divorce monologue"** (Wallerstein & Kelly, 1980), which **the therapist uses to tell the child what other children his or her age in the same situation feel.** The child can relate his or her own feelings to those of other children without initially talking about his own situation. Later, as a child develops a positive rela-

tionship with the therapist, he or she may be able to discuss his or her own feelings.

- Perhaps the single most important intervention strategy involves **ensuring daily successful experiences in the child's life. Therapists may have to work with parents and school officials in either lowering expectations or providing positive feedback to the youngster. Care must be taken not to lower expectations too much because this might either worsen or trigger depression and/or other negative behavior.**
- **Children can be taught to be aware of their feelings and behavior.** Most children can learn ways to avoid the problem, if not the feelings and ideas. Children can change negative thoughts and feelings to positive ones by redirecting their thoughts to pleasant experiences. **Therapists should help youngsters develop their coping skills so that they can initiate change themselves. Such self-initiated behavior is more productive because it is chosen by the child.**
- Another important coping skill for managing guilt or depression associated with parental divorce is to **teach children to use their natural ability to daydream and fantasize in a positive, productive way.** Therapists can encourage the use of this technique by **discussing and supporting the use of the procedure. Children can be expertly guided in the use of fantasy and in planning when and how to use certain daydreams** (Phillips, 1978).
- Therapists can also help youngsters gain self-control by using **positive affirmations** (Downing, 1986). The use of these affirmations is a powerful technique with which children can influence their own patterns of thoughts and actions. **Positive self-talk can help induce relaxation and reduce fear and anxiety. For example, youngsters may be able to limit depressive thoughts and, thus, be less anxious.** With the decreased anxiety, they may be able to become more assertive at home and in school.

Conclusion

Divorce is very much a reality in today's world. Marriage and family therapists are in an excellent position to intervene for children of divorce. **Therapists can also serve as educators of parents and school personnel regarding the effects of divorce on children and what the appropriate adult responses should be.**

The most effective intervention strategies involve preventive education of children (McKnew, Cytryn, & Yahraes, 1983). **All children, with the help of counseling, can be taught the depression-coping and control techniques discussed in this lesson.**

All children will react to their parents' divorce—most negatively. Although talking about feelings is important, counseling experience indicates that **learning tools for change, in addition to exploring feelings, is ultimately far more productive** (Cantwell & Carlson, 1983). **There is no limit to the creative ways therapists and children themselves can use behavioral, affective, and cognitive systems to feel better.**

GLOSSARY

Alimony/Maintenance: Money paid by one ex-spouse to the other for support after a divorce. It lasts for a specific time or until the ex-spouse remarries. It is not automatic.

Child support: Payments made by an absent parent to the custodial parent to pay for a child's expenses, such as education, trips, and medical bills. Child support continues until the child marries, finds full-time employment, reaches a certain age, or finishes college.

Contested divorce: When one or the other parent does not want the divorce or cannot agree on a property settlement, child support, or custody. The judge rules in such cases.

Custodial parent: The parent with whom the minor children legally live as agreed to in the divorce decree.

Custody

***Sole*:** All decisions are made by the custodial parent; the noncustodial parent can have visitation rights.

***Joint physical custody*:** Both parents share responsibility for their children and alternate custody for periods of time...sometimes called alternate or divided custody.

***Joint legal custody*:** Both parents have equal input into decisions that affect children even if the child lives with one parent. This includes decisions about religion and schooling.

***Split custody*:** Each parent receives a child (children) and makes all decisions about the child(ren).

Equitable (Fair) distribution of property: Marriage is viewed as a partnership, and judges can divide it without regarding who holds the legal title to property, pension funds, or medical benefits.

Legal separation: The couple no longer lives together and has formalized the terms of living apart, but the marriage is not ended legally; it is usually the first step to a divorce.

Uncontested divorce: The couple has agreed to the divorce and go to court already in agreement. A mediator may be needed for an uncontested divorce to be successful.

Visitation rights: The agreed-upon visits by the children to the noncustodial parent; they are subject to change.

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QUESTIONS BASED ON THIS LESSON

1. Which of the following is *not* cited as a determinant of the "sleeper effect" of divorce on children?
   - A. Financial pressures on a single-parent family
   - B. Moving to a new school
   - C. Hormonal changes in adolescents
   - D. The remarriage of one or both parents

2. For treating denial in children of divorce, the author recommends the use of:
   - A. Direct confrontation
   - B. Bibliotherapy
   - C. Art therapy
   - D. Switching custody arrangements

3. It is often difficult to treat feelings of guilt and fear of abandonment in children of divorce because:
   - A. The feelings can be irrational, but strong
   - B. Issues about children actually do cause most divorces
   - C. Parental assistance is extremely ineffective in helping to diminish such feelings
   - D. Children are completely unable to understand the complex reasons for divorce

4. In children of divorce, sadness can escalate to depression due to all of the following factors *except*:
   - A. Continuing turmoil in the house (including custody battles or financial arguments)
   - B. The mother or father no longer visits the child
   - C. The child experiences frequent moves to different neighborhoods
   - D. The child develops relationships with strong role models other than his or her parents

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Directions in
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VOLUME 1 • LESSON 2

Family Diagnostic Testing: A Neglected Area of Expertise for the Family Psychologist

Dennis A. Bagarozzi, PhD

Dr. Bagarozzi is in private practice in Atlanta, GA.

VOL. 1

NO. 2

KEY POINTS

- Family diagnostic testing is used to provide specific information about a family problem constellation or dynamic. It should be used in conjunction with personality measures and assessments that highlight interpersonal dynamics and personal functioning.

- A family diagnostic profile based on the results of tests is usually forwarded to the referring therapist. Theoretical orientation of the therapist will determine which scales and tests are used. Practical considerations are also used for instrument selection.

- The Dyadic Adjustment Scale is used to determine dynamic satisfaction, dyadic cohesion, dyadic consensus, and affectual expression.

- Scores on the SIDCARB test, which reveals the social exchange processes of the family, are separated into three factors: Factor I evaluates satisfaction with fairness of the social exchange process in marriage; factor II determines the degree of internal-psychological barriers to separation; and factor III reports the external-circumstantial barriers to separation and divorce.

- The Conflicts Tactics Scale helps determine the strategies (e.g., verbal aggression, verbal reasoning, passive-aggressive tactics) the family uses to deal with confrontations.

- The FACES III test reveals how a family perceives itself and its functioning, and how the family would like itself to function.

- The 10-item Family Environment Scale Profile reveals how the social climate of the family is perceived by its members. This scale assesses three underlying dimensions of family life: relationship, personal growth, and systems maintenance.

- The Personal Authority in the Family Systems Questionnaire (PAFS-Q) measures the adult's ability to function in his or her own family while maintaining an age-appropriate relationship with his or her family of origin.

- Family diagnostic testing can assist in determining problem areas in families and suggest the direction for follow-up individual and family therapy.

Introduction

The selection of appropriate tests, questionnaires, instruments, observation procedures, and interviewing formats for the purpose of accurate marital and family assessment is an essential part of the therapeutic process. Unfortunately, the selection of reliable and valid assessment instruments and procedures has, until recently, received little attention in the field (Bagarozzi, 1985). Too frequently, tests and procedures developed specifically for the diagnosis and assessment of individual personality traits or characteristics, intrapsychic processes, and personal functioning are used instead of reliable, valid instruments and interviewing procedures created specifically for marital and family assessment and evaluation. **Personality measures and assessments designed to highlight intrapersonal dynamics and personal functioning can be used to complement measures of marital dynamics and family processes** (Bagarozzi, 1985). **However, they cannot and should not be used in place of reliable, valid instruments designed for the marital unit or family system.**

Appropriate measures and procedures for assessing marital or family functioning can be selected in two ways. First, the therapist can choose from a number of instruments that have been proven to be reliable and valid measures of some important theoretical construct or group of related constructs and are **consistent with the practitioner's theoretical/clinical orientation. Theory essentially dictates which instruments or procedures one uses.**

For some therapists, however, theoretical purity may be of minor importance; these practitioners are frequently **problem- or issue-focused. Such therapists tend to use instruments or interview formats that allow them to assess marital/family functioning as it relates to a particular presenting problem** or constellation of problems. Practical considerations, therefore, offer a second way to guide instrument selection.

In my consulting practice, **couples and families are frequently referred to me by therapists who request marital or family diagnostic testing. In most instances, the referring therapist asks for specific information about a particular family problem constellation or family dynamic.** In a few instances, I have been asked to make assessments according to a particular school or theory of family functioning. However, this is the exception rather than the rule, because therapists who adhere rigidly to only one theoretical view or epistemologic orientation usually prefer to do their own evaluations. For the most part, the instruments and procedures I use in family diagnostic testing are selected because they are helpful in shedding new light on the presenting problems and the attendant family dynamics. **After testing has been completed, a family diagnostic profile report is written and forwarded to the referring therapist.** Usually, some treatment suggestions are given in the final report.

I have selected the Smith family system (Mr. Smith, Mrs. Smith, and their children Michael and Ellen) to use as a basis for exploring the various testing instruments. An example of the Smith's family diagnostic profile report, with recommendations for treatment, is presented in Table 1.

Findings, Interpretations, and Intervention Recommendations for the Smith Family

ADJUSTMENT SCALES:

The self-report measures of marital quality, adjustment, and satisfaction were similar for both Mr. and Mrs. Smith. (Please refer to Appendix A at the end of the lesson for detailed descriptions of each self-report questionnaire.) Both spouses perceive their marriage to be severely distressed and in need of repair. Mr. Smith's score on the Locke-Wallace Marital Adjustment Test was 69, and Mrs. Smith's score on this measure was 65; both

Table 1
FAMILY PROFILE REPORT

Family Members Present for Testing		***Presenting Complaint(s)***
John Smith (age 38):	Father	Stress
Mary Smith (age 36):	Mother	Depression
Michael Smith (age 15):	Son	Uncooperative behavior and some alcohol abuse
Ellen Smith (age 12):	Daughter	Nonsymptomatic

Assessment In Instruments and Procedures Used

I. **Questionnaires** *(See Appendix A)*
   1. Locke-Wallace Marital Adjustment Scale (Locke & Wallace, 1959)
   2. Dyadic Adjustment Scale (Spanier, 1976)
   3. Kansas Marital Adjustment Scale (Schumm et al., 1983)
   4. Spousal Inventory of Desired Changes and Relationship Barriers (SIDCARB) (Bagarozzi, 1983)
   5. Exchange Orientation Inventory (Murstein et al., 1977)
   6. Conflict Tactics Scales (Straus, 1979)
   7. Family Adaptability and Cohesion Scales III (FACES III) (Olson et al., 1985)
   8. Family Environment Scale (Moos & Moos, 1981)
   9. Personal Authority in the Family System Questionnaire (PAFS-Q) (Williamson et al., 1984)

II. **Behavioral Tasks Assigned for Observational Study of Family** *(See Appendix B)*
   1. Marital problem identification task
   2. Family problem identification task
   3. Marital conflict resolution task
   4. Family conflict resolution task
   5. Family planning and execution task

III. **Special Considerations: Interview Format** *(See Appendix C)*
   1. Circular questioning regarding identified patient's symptom
   2. Circular questioning format (Penn, 1982)

IV. **Observational Measures** *(See Appendix D)*
   1. Beavers-Timberlawn Family Evaluation Scales (Lewis et al., 1976)
   2. Marital Interaction Coding System III (MICS III) (Weiss & Summers, 1983)
   3. Relational Communication Coding System (Ericson & Rogers, 1973; Rogers, 1972)

V. **Special Considerations: Individual Measures** *(See Appendix E)*
   1. Mrs. Smith: Depression Inventory (Beck & Beamesderfer, 1974)

scores fall within the maladjusted range. Similarly, scores for both spouses on the Kansas Marital Adjustment Scale show them to be very dissatisfied with each other, their marriage, and their relationship in general. The **four dimensions assessed by the Dyadic Adjustment Scale (dyadic satisfaction, dyadic cohesion, dyadic consensus, and affectional expression)** are shown in Table 2.

Table 2
DYADIC ADJUSTMENT SCALE SCORES FOR MR. AND MRS. SMITH

DAS	*Factor*	*Mr. Smith*	*Mrs. Smith*
I.	Satisfaction	29	25
II.	Cohesion	6	8
III.	Consensus	40	37
IV.	Affectional expression	5	4

The scores for both spouses, on all four factors, fall within the severely distressed range. As with the Locke-Wallace measure of marital adjustment, Mrs. Smith's scores were slightly lower than her husband's, but these differences should not be considered qualitatively or quantitatively significant because both spouses' scores fall within the same category.

From an intrapersonal standpoint, Mr. Smith's symptoms of stress and Mrs. Smith's depression can be interpreted as intrapsychic compromises they have developed to cope with certain negative and unacceptable affects (e.g., anger, rage, and resentment). However, from both a sociobehavioral exchange perspective and an interpersonal interactionist perspective, these symptoms can be seen as both spouses' attempts to bring about a more equitable system of exchanges in the marriage. In this sense, the symptoms are seen as coercive maneuvers designed to reduce one's own inputs and to force one's spouse to increase his or her inputs into the marriage. Such **negative, reciprocal exchanges are typical of severely distressed relationships. Research has shown that positive reciprocity and negative reciprocity (i.e., the exchange of rewards and punishments) are independent dimensions of marital interaction.** Therefore, the therapist must attend to both dimensions in devising a viable treatment program. **Typically, the therapist helps the couple devise more equitable exchanges** and increases in positive reciprocity while helping the couple decrease negative exchanges, punishments, and the like.

SPOUSAL INVENTORY OF DESIRED CHANGES AND RELATIONSHIP BARRIERS:

A detailed analysis of the social exchange process can be seen in the Smiths' Spousal Inventory of Desired Changes and Relationship Barriers (SIDCARB) scores (Table 3) (Bagarozzi & Pollane, 1983). **Factor I (satisfaction with the fairness of the social exchange process in the marriage and the degree of behavioral change desired in one's spouse in the 10 areas of marital exchange)** shows that Mr. and Mrs. Smith desire a considerable amount of change in their exchange system. Mr. Smith's standard score of 75 is 2½ standard deviations above the mean. Both of these spouses perceive the conjugal exchange system to be grossly inequitable and both desire a considerable amount of change if the marriage is to be improved. The first aspect of factor I also measures commitment. Both Mr. and Mrs. Smith scored in the moderate range on this variable. However, **the degree to which each spouse is committed to making the necessary changes required to move the relation-**

Table 3
SIDCARB SCORES FOR MR. AND MRS. SMITH

SIDCARB Factor	*Mr. Smith*	*Mrs. Smith*
I.	75	82
II.	72	57
III.	65	77

ship in a more positive direction can only be measured by each spouse's willingness to negotiate differences, compromise, and complete homework assignments. (Appendix B provides examples of three basic types of behavior task assignments.)

There are significant differences in how Mr. and Mrs. Smith perceive the barriers to divorce and separation in their marriage. Mrs. Smith reports a fairly strong **internal-psychological barrier (factor II)**, while Mr. Smith's perception of these barriers to relationship termination approximately reflect the mean. Scores for factor II were 72 for Mrs. Smith and 57 for Mr. Smith. **External-circumstantial barriers to separation and divorce (factor III)** were slightly lower for both spouses, but Mrs. Smith still perceives higher barriers to relationship termination than does her husband. These scores were 77 and 65, respectively.

These scores reveal much about the power dynamics in this marriage. Mr. Smith has much more power than Mrs. Smith by virtue of the "principle of least interest." **The person who perceives fewer barriers to relationship termination has more power to influence the person who perceives higher barriers; the person who perceives higher barriers is more dependent upon the relationship than the person who perceives fewer barriers.** It is not surprising that Mrs. Smith presents with depression. She is caught in what has been termed a "nonvoluntary" marriage (Bagarozzi & Wodarski, 1977) and has resorted to the use of a meta-strategy to influence her husband—she has become symptomatic. This interpretation reflects family systems theory as well as the sociobehavioral interpersonal interpretation offered earlier. **One would expect Mrs. Smith's depression to lift if she could learn to communicate her needs and desires more directly to her husband and if she could learn how to negotiate more satisfactory and equitable exchanges.**

EXCHANGE ORIENTATION INVENTORY:

A sociobehavioral exchange and contingency contracting approach should be attempted with this couple at the outset of treatment, because both Mr. and Mrs. Smith scored very high on the Exchange Orientation Scale (Murstein et al., 1977), indicating that they both perceive their marriage in terms of an exchange paradigm. However, because both spouses perceive such great discrepancies in their marital exchange system, it might be important for the therapist to **explore with each spouse his or her viewpoint concerning distributive justice, sharing, and exchange in marriage. More than likely, Mr. and Mrs. Smith are applying different rules for exchange, and this may be at the root of their conflict.**

CONFLICT TACTICS SCALE:

The therapist may wish to consider additional issues in treating this family. For example, further individual testing of Mr. Smith using measures of personal and occupational stress might be helpful in pinpointing the sources of his stress. Relaxation training may also be used in conjunction with marital/family work to help Mr. Smith reduce external life stresses. This is important because all family members, including Mr. Smith, reported (on the Conflict Tactics Scales [CTS]) that Mr. Smith has a history of being physically violent with his wife and children. Although there have been fewer temper outbursts in the last few years, and Mr Smith has not been violent with his spouse for over 3 years, the threat of physical violence hangs over this family. This can be seen as another reason for Mrs. Smith's depression and the increase in Mr. Smith's stress. In the family interview, Mr. Smith recognized that he had learned to alleviate personal stress by "blowing off steam" and by being physically assaultive. However, these cathartic releases only gave him temporary relief of his chronic stress. Mr. Smith acknowledged that he must learn more functional and more prosocial ways to reduce stress and resolve interpersonal conflicts. **Scores on the CTS** (Straus, 1979) **indicate that Mr. Smith uses verbal aggression more frequently than verbal reasoning when communicating with Mrs. Smith and their children. Mrs. Smith, on**

the other hand, was found to resort to passive-aggressive tactics to express her anger (e.g., sulking, refusing to talk, and performing acts to spite Mr. Smith). Again, these responses are typically seen in spouses who perceive themselves to be powerless and confined to a nonvoluntary marriage.

Training in more functional and direct communication, problem solving, and conflict negotiation may prove to be helpful in reducing stress and depression in Mr. and Mrs. Smith.

Additional social skills training in assertive responding may be taught to all family members at a later time in treatment, once Mr. Smith has learned to relax and when he no longer resorts to using physical violence to resolve interpersonal conflict.

FAMILY ADAPTABILITY AND COHESION SCALES III:

Perceived and ideal versions of Family Adaptability and Cohesion Scales III (FACES III) were administered to all family members. These findings are reported in Table 4.

Table 4
FACES III Scores for the Smith Family

Family Member	*Perceived*	*Ideal*
Mr. Smith	Chaotically disengaged EXTREME	Rigidly enmeshed EXTREME
Mrs. Smith	Chaotically connected MID-RANGE	Structurally enmeshed MID-RANGE
Michael (IP)	Chaotically disengaged EXTREME	Structurally separated BALANCED
Ellen	Chaotically disengaged EXTREME	Rigidly disengaged EXTREME

The interpretation of FACES III will begin with a discussion of Ellen's scores, because they represent the type of responses typically given by the nonsymptomatic child in a two-child family system. She perceives herself as totally isolated from all members of her family system. (For example, circular questioning [Appendix C] revealed that Ellen is the least concerned with her brother's substance abuse problems.) In Ellen's view, the system itself is chaotic—leaderless and lacking direction. Her isolation, however, is self-imposed and serves defensive and self-preserving functions. **By withdrawing and being nonconspicuous, she has been able (up to this point) to avoid being scapegoated by other family members, and she has been able to avoid (to a large degree) being triangulated into her parents' struggles.** Ellen's report that she had been scapegoated by her parents whenever she tried to help her brother (the identified patient [IP]) or come to his aid is a pattern frequently seen in families in which scapegoating is the central mechanism used by parents. **Typically, the nonsymptomatic child has learned to protect himself or herself from becoming the target by fulfilling the role of "good" or "model" child. It is not unusual for such model children to develop a strong sense of guilt for abandoning the IP.** (This sense of guilt may evidence itself in a variety of ways later in life.) **Withdrawal from family interaction as a self-preservation strategy in families with only two children also prevents the formation of sibling coalitions, which often allow siblings to band together for mutual support, comfort, and solace.** Not surprisingly, there is little evidence of a sibling coalition between Ellen and Michael.

It is also not surprising that Ellen does not wish to become closer to other family members, because the effects of closeness are not predictable; she would rather be left alone. However, her need for order and structure cause her to go to the opposite extreme in her formulations of her ideal family. This flip-flop from one extreme to the other is an attempt to compensate for the perceived lack of structure and leadership by imposing a rigidly inflexible structure. Finally, inquiries into why Ellen does not desire more closeness with other family members in her "ideal" reveal that she would like to be "a little closer" to her mother but fears becoming too involved with her father. Because of the incestuous threat such closeness often poses to young adolescent girls who are aware of deep rifts between the parents, Ellen's desire to remain fairly isolated is quite understandable.

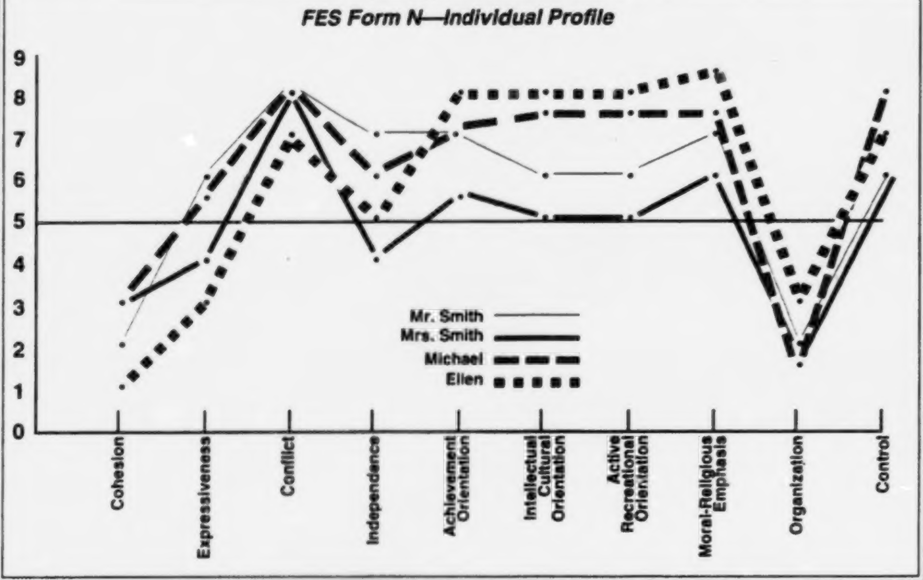
Mrs. Smith's responses concerning how she perceives her family's customary way of functioning places her in the mid-range category of functioning according to the Circumplex Model of Marital and Family Systems (CMMFS), upon which the FACES III measure is based. Her ideal for how the family should function also places her in the mid-range category. Interviews with Mrs. Smith reveal that she would like more closeness with both of her children, especially her son, and a more predictable (structured) relationship with her husband; however, she does not desire increased intimacy with him.

Mr. Smith perceives the family to be chaotically disengaged. He would like to have more close and intimate relations with all family members. Unlike his daughter, who also perceives the family and herself as chaotically disengaged, Mr. Smith's isolation does not appear to be self-imposed and defensive. He sees himself as responding to rebuffs from Mrs. Smith. He refers to her as "cold" and "distant." Ellen's uneasiness with the prospect of a closer relationship with her father becomes more understandable in the light of Mr. Smith's responses.

Finally, Michael (the IP) also sees the family as chaotically disengaged. His ideal family structure, however, is one in which family members are structurally separated. Michael's ideal family design is the only one that falls within the healthy balanced range of family functioning according to the CMMFS. This balanced ideal allows for a definite family structure having designated leaders, stable roles, firmly enforced rules, and parents who are mainly responsible for making family decisions. The degree of closeness or interpersonal intimacy in structurally separated family systems is one in which personal distance is preferred, there are clear ego boundaries between family members, emotional separateness and differentiation exist, and personal time alone and separate physical space are preferred to family cohesion. In structurally separated family systems, the individual's orientation is focused outside the family, and individual friendships are prized more than family group friendships. Family members pursue personal interests, and recreational activities tend to be engaged in individually or with persons outside the family system itself.

If one looks at the perceived views of all family members, they all fall within the extreme, dysfunctional range of family structure and family process. These views coincide with the perceptions of alcoholic families and chemically dependent family systems found in a number of clinical research studies (Bonk, 1984; Killorin & Olson, 1984; Olson & Killorin, 1985). **The Smith family, therefore, can be seen as a typical family where substance abuse is the presenting problem. All the members of the family, except Ellen, desire more closeness and intimacy. They agree that there is a definite need for structure. Taking these findings into consideration, a straightforward behavioral-structural approach designed to bring about a much-needed family structure is indicated.** Efforts should be made to have Mr. and Mrs. Smith turn to each other for their intimacy needs rather than to their children. Similarly, intervention should be geared for helping Michael gain more closeness with his father. However, there is a tendency for Mrs. Smith to want to bond with her children. Therefore, the therapist might attempt to help Mrs. Smith develop appropriate levels of intimacy with her children and not to use them to compensate for the emotional isolation she experiences in her relationship with Mr. Smith. Essentially, **building an appropriate parental coalition with definite boundaries between the parental and sibling subsystems should be a primary structural goal of treatment.**

Figure 1
FAMILY ENVIRONMENT SCALE (FES) PROFILE



Another concern is how to bring Ellen into the family system in a way that does not place her in a scapegoat position and does not pose a threat to her by pushing her too close to Mr. Smith. Because Ellen does verbalize a desire to be closer to Mrs. Smith, building appropriate mother-daughter cohesion may be the best way to begin this process.

FAMILY ENVIRONMENT SCALE:

Figure 1 shows the **Family Environment Scale** (FES) profile for the Smith family. **The FES was developed to measure a family member's perception of the social-environmental characteristics of his or her family system.** The social climate perspective assumes that family environments can be accurately measured and that these environments exert a directional influence on family members' behavior. There are 10 nine-item subscales that assess **three underlying dimensions of family life**: the **relationship dimension, the personal growth dimension, and the systems maintenance dimension.**

The Relationship Dimension

The relationship dimension is comprised of three subscales: cohesion, expressiveness, and conflict. Research has shown that the cohesion dimension of the FES does not correlate very highly with cohesion as measured by FACES III. **Because FACES III has much more empirical support for the validity of its cohesion dimension, FACES III should be considered the measure that most accurately assesses this construct.** It has been suggested that the FES cohesion dimension actually represents a measure of "family support" (Russell, 1980;

Russell & Olson, 1982). My interpretation of the Smith's profile uses the FES cohesion label as an indication of the supportive atmosphere of the Smith family and not as another measure of cohesion itself.

The Personal Growth Dimension

Depending upon the nature of the presenting problem, the importance of the **personal growth** dimension for developing treatment goals and foci will vary from family to family. This dimension consists **of five variables: independence, achievement orientation, intellectual-cultural orientation, active-recreational orientation, and moral-religious orientation**. In using this measure, it has been my experience that parents and children usually agree upon the importance of these variables in family life. **Parent-child conflicts do develop, however, when the parents are dissatisfied with the degree to which their children's behavior is perceived to be consistent with the family's orientation about this dimension.**

The Systems Maintenance Dimension

Moos and Moos (1981) have shown that the severity of alcoholic patients' psychiatric disturbance as measured by the Minnesota Multiphasic Personality Inventory (MMPI) correlated significantly with all three subscales of the relationship dimension (cohesion, expressiveness, and conflict) and with only one item, independence, on the personal growth dimension. Similarly, only one of the two subscales of the third dimension, **systems maintenance, was found to correlate significantly with severity of psychiatric-illness scores of alcoholic patients as measured by the MMPI. This subscale was family organization. Family control, the second subscale of this third dimension, was not found to be significantly related to psychopathology in alcoholic patients.** Keeping these findings in mind, I have limited my discussion and suggestions for intervention to information gathered from the following FES items: cohesion, expressiveness, conflict, independence, and family organization.

Analysis of the Smith's Family Environment Scale

In looking at the FES profile for the Smith family, it becomes apparent that all family members generally agree about the social-environmental climate of the family. Essentially, all family members perceive interpersonal relationships as low in cohesion (i.e., interpersonal support). The men, however, tend to perceive the family as more expressive than the women. We may understand this discrepancy by noting that Mr. Smith is hot tempered and that Michael, the IP, has a history of acting out. It is possible, given the past history of physical abuse by Mr. Smith, that Mrs. Smith and Ellen are much more reluctant to express their true feelings openly. Withdrawal by the women in this family, as manifested by Mrs. Smith's depression and Ellen's self-imposed isolation, may be a safer alternative to open disagreement with Mr. Smith. Evidence to support this interpretation was gathered during observations of the Smith family's attempts to solve problems, negotiate conflict, and plan a family project. More will be said about these observations later in this lesson.

Based on the interviews conducted with this family and observations of the family attempting to set goals, solve problems, and negotiate conflict, FES scores for independence can be said to reflect traditional sex-role orientations and expectations for the children's behavior. Additional evidence for this interpretation comes from Mr. and Mrs. Smith's requests for change as measured by SIDCARB. Neither spouse desired changes in the areas of **marital roles and tasks. Usually, dissatisfaction with this area of marital exchange indicates a conflict over traditional vs. egalitarian role sharing and task assignments.**

It is important to consider this family's subcultural, ethnic, and regional identifications—as well as religious values—when attempting to determine whether a traditional sex-role orientation is functional or dysfunctional for the growth and development of all

family members. The Smiths share a strong fundamentalist Christian value orientation, which supports traditional family sex-role behaviors. Any interventions perceived by family members as attempts by the therapist to modify the family's basic value orientation will probably serve as an obstacle to forming a trusting therapeutic relationship with the parents. Although Mrs. Smith's depression may be symptomatic of her dependent position vis-à-vis Mr. Smith, the therapist's attempts to create a more even power distribution and power sharing relationship between the spouses should be tempered with an understanding of the Smith family's sociocultural, ethnic, regional, and religious values.

Finally, there is a general consensus among family members that the family is poorly organized, and that interpersonal attempts to dominate, control, and manipulate others are characteristic of the family's mode of functioning. Both Michael and Ellen perceive higher levels of control than do Mr. and Mrs. Smith. This is not an unusual perception for teenagers. **Adolescents frequently perceive their parents as trying to control them.** However, **it has been my experience to find the combination of high conflict, low family organization, and high control to be characteristic of chaotic and disorganized family systems.** Again, this clinical observation is supported by all family members' perceptions of chaos and disorganization as reflected in their scores on FACES III. Obviously, **a primary treatment goal is to help the family develop a viable organizational structure.**

PERSONAL AUTHORITY IN THE FAMILY SYSTEMS QUESTIONNAIRE:

The final self-report questionnaire selected for inclusion in the battery of tests given to the Smith family is the **Personal Authority in the Family Systems Questionnaire (PAFS-Q), which measures an adult's ability to function autonomously within his or her own family-of-procreation while maintaining an age-appropriate and intimate adult relationship with his or her family-of-origin.** Personal authority exists on a continuum. At the positive pole, personal authority is characterized by peerhood and relational equality with one's parents. The negative extreme is characterized by intergenerational intimidation. **The PAFS-Q consists of eight fairly independent subscales: spousal intimacy, spousal fusion-individuation, nuclear family triangulation, intergenerational intimacy, intergenerational fusion-intimidation, intergenerational triangulation, intergenerational intimidation, and personal authority.**

The first two factors, spousal intimacy and spousal fusion-individuation, can be used as validity checks for cohesion (FACES III) and support-cohesion (FES). For Mr. and Mrs. Smith, these scores are consistent with FACES III and FES findings. Both spouses perceive their relationship to be low on intimacy and low on fusion. Both Mr. and Mrs. Smith received similar scores for nuclear family triangulation and intergenerational triangulation. Neither spouse perceives himself or herself to be the focal point of such triangulations.

However, Mrs. Smith received very high scores for intergenerational intimacy, intergenerational fusion, and intergenerational intimidation, whereas Mr. Smith's scores on these three factors were only mid-range (i.e., average). Mr. Smith evidenced a much higher level of personal authority than did Mrs. Smith. Essentially, Mr. Smith appears to have achieved much more autonomy, independence, and personal authority than has Mrs. Smith. Mrs. Smith, on the other hand, shows many of the characteristics of one who has not separated sucessfully from the family-of-origin. She is docile, dependent and under-assertive. Under such conditions, **the spouse who has separated unsuccessfully from the family-of-origin frequently transfers dependency to his or her mate**

and attempts to re-create the enmeshed (and sometimes symbiotic) union with the spouse after marriage. When this attempt fails, the spouse begins to feel abandoned, isolated, alone, alienated, and depressed. As often happens, this spouse turns to one of the children for closeness and intimacy. Such parent-child closeness is often found in families where incest, drug abuse, and/or alcoholism are present. In this family, Mrs. Smith appears to have turned to Michael. One way of understanding Michael's acting out and alcohol abuse is to view it as his attempt to separate and distance himself from Mrs. Smith. Taking this into consideration, **two therapeutic goals should be considered: (1) To help Michael achieve separation-individuation in a more appropriate, socially acceptable manner; and (2) to help Mrs. Smith establish a more satisfying and appropriately intimate relationship with her husband.** This will also help reduce Ellen's anxiety concerning her fears about closeness to her father.

Summary of Family Observations

As a couple, Mr. and Mrs. Smith had no difficulty identifying problems in their marriage. In fact, they were able to do this without the aid of SIDCARB. Similarly, the Smith family had no difficulty identifying family problems that needed attention. However, the Smiths were unable to resolve the marital difficulty selected for the purpose of this assessment. Analysis of the Smiths' videotaped conflict resolution attempts showed them to use punishments, coercion, and negative reinforcements much more frequently than positive reinforcements as defined by the Marital Interaction Coding System III (Appendix D). According to the Relational Communication Coding System (Appendix D), the Smiths appear to have an interactive pattern of rigid complementarity, with Mr. Smith in the dominant position. The couple seems to be deadlocked in a "zero sum" power struggle, with Mr. Smith in control. Mrs. Smith appears to resort to passive-aggressive and manipulative strategies to gain leverage in the marriage.

Training in functional communication and "non-zero sum" conflict negotiation strategies would help Mr. and Mrs. Smith disrupt their rigid, homeostatic pattern. This straightforward structural-behavioral approach should be attempted initially. It could be used to help build the much needed parental coalition, which is lacking. If this can be done, Mr. and Mrs. Smith can begin to work together as a team to bring their son's behavior under control.

Observations of the entire family's attempt to identify a problem and devise a solution upon which all family members can agree proved to be a futile exercise for the Smith family. **The Beavers-Timberlawn Family Evaluation Scales** (Appendix D) **were used to rate the family's performance.** Thirteen of the 14 BTFE scales were used in the analysis, which is reported below.

OVERT POWER:

The Smith family is characterized as having **moderate-marked dominance**. Mr. Smith has the most overt power. Interventions designed to move the family toward a more fair (but not necessarily a more egalitarian) power-sharing structure in which Mr. Smith is not always in the dominant position is recommended.

PARENTAL COALITION:

The Smith family has a weak parental coalition. **Strengthening the parental subsystem is needed.**

CLOSENESS:

Again, this is not a cohesive and supportive family system. It is characterized by isolation and distancing. Interventions should be developed that help bring about appropriate levels of closeness and separateness. Helping family members negotiate and develop mutually satisfying levels of interpersonal closeness and distance may prove a challenge for the therapist. (I do not believe that this will occur easily or swiftly.)

GOAL-DIRECTED NEGOTIATION:

This family is "poorly efficient" in this area. Training in family "non-zero sum" conflict negotiation and functional communication should also be attempted with the entire family.

CLARITY OF EXPRESSION:

This family's ability to express itself clearly and honestly falls in the **vaguely clear and hidden** range. Again, communication training may be very helpful.

RESPONSIBILITY FOR ONE'S OWN ACTIONS:

As mentioned earlier, much scapegoating occurs in the Smith family. Also, a considerable amount of speaking for others, mind reading, and projection takes place. Michael is the only person who appears to take responsibility for his own actions; he seems highly identified with his "bad child" or "black sheep" role in the family. One way to break this pattern may be to use intervention techniques which **"spread the symptoms."**

INVASIVENESS:

As mentioned above, there is much mind reading and speaking for others in this family. Thus, **the Smith family scored highly on interpersonal invasions. Structured communication training should reduce this considerably.**

PERMEABILITY OF FAMILY MEMBERS:

This dimension is an assessment of each family member's openness to other family members' statements, thoughts, and ideas. Here, the Smith family is evaluated as **unreceptive. Communication skills training may be helpful** here as well.

RANGE OF FEELINGS:

The range of feelings in the Smith family is highly restricted; i.e., the family members tend to mask and hide their true emotions. The degree to which trust can be developed among family members and the degree to which family members can learn not to fear Mr. Smith will depend upon how successful intervention is in **teaching Mr. Smith more socially acceptable and less violent ways to express his negative emotions**. To the extent that he can do this, there may be more security among family members to express their true feelings.

MOOD AND TONE:

The overall affect in this family is depressed. There is a lack of warmth, humor, and optimism.

UNRESOLVABLE CONFLICTS:

The Smiths have numerous severe and unresolvable conflicts, which have existed for some time. A considerable amount of **impairment of family functioning** has resulted. If the family is able to achieve success in resolving even minor conflicts, enough positive reinforcement to provide an incentive may be generated to tackle larger problems.

EMPATHY:

It appears that all family members genuinely attempt to be empathic. However, they fail to maintain empathy for any sustained period of time. In Mrs. Smith's case, what first appears to be empathy for her son actually turns out to be identification with him. Mrs. Smith also tends to project her feelings and ideas onto both children. Again, if the child is silent, as is the case with Ellen, Mrs. Smith's projections may go undetected, and she may appear to be truly empathic. Teaching both children to use functional communication skills may enable them to verbalize their differing opinions and perceptions, thus reducing Mrs. Smith's tendency to accept her projections as valid indicators of what her children think and feel.

GLOBAL HEALTH-PATHOLOGY:

The Smith family rated an 8 on this 10-point Likert-type scale used to rate overall family pathology. (A score of 8 suggests a relatively high level of pathology.)

ANALYSIS:

Essentially, the Smith family is severely distressed and borderline dysfunctional. Intensive family therapy appears to be the treatment of choice. However, if the parents are unable to work cooperatively as a team and are unsuccessful in bringing their son's uncooperative behavior and alcohol use under control, professional placement for him should be considered. Although there are numerous underlying problems in the marital relationship that require attention, once the presenting problem is resolved, Mr. Smith appears to lack sufficient motivation to improve his marriage. Mrs. Smith, on the other hand, appears to be more ready to tackle these marital difficulties.

A straightforward, social skills training, structural-behavioral approach appears to be the most appropriate intervention strategy to adopt initially. If the structural behavioral route proves to be ineffective, a strategic approach may be used later in therapy.

Based upon Mrs. Smith's responses on the Beck Depression Inventory (Appendix E), her depression is considered moderate. Successful marital/family therapy should cause Mrs. Smith's depression to abate. But if her depression worsens, referral for antidepressant medication should be considered. **If Mr. Smith is unwilling to work on the marital relationship once the presenting problem is resolved, individual treatment for Mrs. Smith may be appropriate.**

In true systemic fashion, Michael's presenting problems are symptomatic of a dysfunctional parental relationship. However, his symptoms also might have taken on an existence of their own—an existence independent of their original meaning. For example, these symptoms may now be maintained by forces outside the family system, and Michael may have become substance dependent. The therapist should investigate to what extent this has taken place and whether other treatments should be used to complement family work.

Conclusion

As can be seen from the aforementioned sample family profile report, specific recommendations for treatment are made to the referring clinician. These recommendations are based upon information gathered throughout the testing process. **Traditionally, clinical psychologists have used their expertise in diagnostic testing to make recommendations to referring therapists in their psychotherapeutic work with individual clients. Similarly, intelligence and abilities tests by school psychologists have proven to be invaluable sources of information for teachers and guidance counselors in their work with children.** In keeping with this tradition, **family psychologists can make a much-needed contribution to the fields of family life education and marital/family therapy by providing marital/family diagnostic testing for other practitioners who work with couples and families but who have not been trained in marital/family diagnosis, assessment, and evaluation.**

APPENDIX A

Self-Report Questionnaires

- ***Locke-Wallace Marital Adjustment Test (LWMAT)***
  The LWMAT is a 15-item questionnaire developed to assess levels of marital satisfaction, adjustment, and accommodation of spouses in their marital relationships. Scoring of items are weighted and range from 2–158. The mean (x) score for well-adjusted and satisfied spouses is 135.9. The mean (x) score for dissatisfied and maladjusted spouses is 71.7.
- ***Dyadic Adjustment Scale (DAS)***
  The DAS is a 32-item questionnaire that was designed to assess the quality of dyadic relationships. The mean score for adjusted couples is 114.8. The mean score for maladjusted couples is 70.7. Range is 0–151.
- ***Kansas Marital Adjustment Scale (KMAS)***
  KMAS is a three-item questionnaire designed to measure marital satisfaction. The KMAS also controls for social desirability of responses.
- ***Spousal Inventory of Desired Changes and Relationship Barriers (SIDCARB)***
  SIDCARB is a 24-item Likert-style questionnaire. The behavior and attitudes of spouses are assessed along three factor dimensions: (1) Desired level of behavior change in one's spouse and satisfaction with one's marriage;(2) willingness to separate and divorce one's spouse; and (3) barriers to separation and divorce. Each factor has a standard score of 50 and a standard deviation of 10.
- ***Exchange Orientation Inventory (EOI)***
  The EOI contains 44 items scored on a 5-point Likert scale and is designed to assess the degree to which spouses conceptualize their relationship according to the norms of equitable distribution of resources and reciprocity. The higher one's score, the higher one's exchange orientation is thought to be.
- ***Conflict Tactics Scale (CTS)***
  This scale is designed to measure an individual's responses to situations within the family that often produce conflict. There are 17 Likert-like items, and subjects are asked to indicate the number of times (within the past 12 months) that they have resorted to using each particular conflict resolution strategy. The CTS can be administered as a questionnaire or as part of a clinical interview. There are three factor-derived subscales: reasoning, verbal aggression, and physical violence. Although scores are weighted for each of the three subscales, the scoring is less important than determining to what extent physical violence is used within a particular family system.
- ***Family Adaptability and Cohesion Scales III (FACES III)***
  FACES III is a self-report instrument that measures two dimensions of family process: adaptability and cohesion. Twenty items, 10 for adaptability and 10 for cohesion, yield scores that range from 10–50 for each subscale. These scores are plotted on a circumplex model yielding 16 relationship types.
- ***Family Environment Scale (FES)***
  The FES is a 90-item self-report scale developed to measure the social environments of families. This atheoretical measure is comprised of 10 subscales. Scores for each subscale range from 0–9.
- ***Personal Authority in the Family System Questionnaire (PAFS-Q)***
  The PAFS-Q is a lengthy 132-item questionnaire yielding eight scores: one score for each of the eight subscales (spousal intimacy, spousal fusion/individuation, nuclear family triangulation, intergenerational intimacy, intergenerational fusion/individuation, intergenerational triangulation, intergenerational intimidation, and personal authority). Ranges of scores and means for each score differ according to the particular subscale.

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APPENDIX B

Behavioral Task Assignments

A multitude of stimulus tasks can be assigned to couples and families so that the therapist can observe marital/family interaction for purposes of diagnostic assessment and evaluation. Depending upon the information that the therapist wishes to gather, stimulus tasks can be broken down into three basic types:

- ***Problem identification assignment***
  This task can be a simple assignment given to the couple or family that asks the members to identify a problem in the marriage/family that all participants agree needs resolution. The interaction among family members allows the therapist to assess the system's ability to identify a problem in a way that makes resolution possible and gives valuable information about the couple/family processes that are getting in the way of problem identification. The problem can be one whose cause is external to the system (e.g., the recent unemployment of a spouse) or one that comes from within the system itself (e.g., husband and wife continually argue about how to budget their finances).
- ***Conflict resolution assignment***
  This task assignment can be accomplished in two ways. First, if, during the problem identification assignment, the couple/family pinpoints an interpersonal conflict that comes from within the system itself, the members of the system can be instructed to resolve the interpersonal conflict in a way that is satisfactory for all involved parties. Second, if standardized instruments have been given to the family members, the therapist can ask the couple/family to resolve a particular problem or interpersonal conflict identified as a concern by the couple, parents, identified patient, or children. Here again, the system's ability to solve the problem or resolve the conflict is assessed and any structural or process dynamics that hamper successful problem solving or conflict negotiation are identified.
- ***Family planning and task execution***
  Many couples and families seeking therapy are unable to plan an activity and carry it out with any measure of success. Identifying an agreed-upon goal and developing the leadership-followship patterns necessary to achieve the goal requires some type of hierarchical arrangement. The task can be a simple directive to the family such as: "Plan an activity that everyone will enjoy and that you will be able to complete or accomplish before our next session." How well the family does with this task gives the therapist some indication of the degree to which hierarchical arrangements are successful, flexible, and functional. It also gives the therapist some indication about how responsive the couple or family will be to performing homework assignments given in therapy.

APPENDIX C

Circular Questioning

Circular questioning is a technique developed by the Milan group under the leadership of Selvini-Palazzoli. **This technique is designed to give the therapist valuable information about how the family functions as a system and how the unique interactions of family members maintain the family's problem, symptom, etc.** The focus of the interview is the family's here-and-now (current problem). This is an extremely difficult technique to master because it requires translating all statements made by family members into relationship dynamics; therefore, the therapist must have a thorough understanding of family-systems theory.

A basic assumption about this approach is that the presenting problem is paradoxically maintained by the family members' attempts to resolve it! **Questions, asked by the therapist, are formulated to assess faulty hierarchical power arrangements, coalitions, triangular patterns, and dysfunctional behavioral sequences in which the problem or symptom is thought to be encased.** The therapist uses the information gathered from the family to formulate hypotheses about the family's dysfunctional style and to devise ritual prescriptions and/or paradoxical methods to free the family from its dysfunctional cycle.

APPENDIX D

Observational Measures

- ***Beavers-Timberlawn Family Evaluation Scales (BTFES)***
  These scales consist of seven subscales (14 items) that are loosely derived from systems theory. A considerable amount of supervised training is required in order to use this observational rating scale. Each subscale is a Likert type scale having nine separate anchoring points (e.g., 1, 1.5, 2, 2.5, 3, 3.5, 4, 4.5, 5). Variables assessed include: family structure, family mythology, goal-directed negotiation, autonomy, family affect, and global family health-pathology.
- ***Marital Interaction Coding System (MICS)***
  The MICS is a behavioral observation coding system that requires a considerable amount of training and supervision before one can competently use it. The latest version has 32 separate codes that cover verbal and nonverbal realms of marital interaction. Speaker and listener are both coded in 30-second units. This observational coding system is suited for research settings but is impractical for everyday clinical practice.
- ***Relational Communication Coding System (RCCS)***
  The RCCS is based upon systems theory and the work of Gregory Bateson and colleagues. It was designed to measure the control dimension of ongoing messages in dyadic relationships. This is a highly sophisticated coding system that requires extensive training to use and interpret. Although there is a considerable body of empirical support for this procedure's reliability and validity, it is so time consuming that its use as a clinical tool is questionable. However, once a person is trained in this coding procedure, he or she should be able to make a fairly good estimate of the control pattern that characterizes a particular dyad. Translating these observations into clinical strategies, however, requires a considerable degree of clinical competence and experience.

APPENDIX E

Beck Depression Inventory

This 21-item questionnaire was developed by Aaron Beck to assess the severity of the respondent's depression. There are no arbitrary cut-off scores, since any cut-off points are determined by the characteristics of the sample under consideration. Nevertheless, Beck offers the following scores as guidelines:

Range 0–63

Normal range	=	0–9
Mild depression	=	10–15
Mild/Moderate	=	16–19
Moderate/Severe	=	20–29
Severe depression	=	30–63

QUESTIONS BASED ON THIS LESSON

5. According to the author, which of the following is a characteristic of disorganized family systems?

A. High conflict and high control

B. High conflict and low control

C. Low conflict and high control

D. Low conflict and low control

6. With regard to the Smith family discussed in this lesson:

A. The son's substance abuse was the presenting problem

B. Mrs. Smith, a manic depressive, had to be referred to a physician for pharmacotherapy with lithium

C. The daughter's depression was the presenting problem

D. Only one member of the family (Mr. Smith) genuinely attempted to be empathic

7. As discussed in this lesson, the nonsymptomatic child in a dysfunctional family is likely to:

A. Become a discipline problem in school

B. Eventually become corrupted by the symptomatic sibling

C. Grow closer to the other sibling

D. Assume the role of the "model" child

8. Which of the following statements is *false*?

A. The Family Adaptability and Cohesion Scales III (FACES III) measures adaptability and cohesion within the family unit

B. The Spousal Inventory of Desired Changes and Relationship Barriers (SIDCARB) provides a measurement of marital satisfaction, willingness to separate and/or divorce one's spouse, and barriers to separation

C. The Locke-Wallace Marital Adjustment Test (LWMAT) assesses marital satisfaction, adjustment, and accommodation of spouses

D. The Future Earnings Scale (FES) measures the potential of the family to become financially stable

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Directions in Marriage and Family Therapy

VOLUME 1 • LESSON 3

Understanding and Treating the Remarriage Family

Florence W. Kaslow, PhD

Dr. Kaslow is Director, Florida Couples and Family Institute, West Palm Beach, FL; Visiting Professor of Medical Psychology in Psychiatry, Duke University Medical Center, Durham, NC; and Visiting Professor of Psychology, Florida Institute of Technology, Melbourne, FL. She was the first president of the International Family Therapy Association.

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KEY POINTS

- One in five American families with children under 18 years of age (over 5 million) is a remarriage family.

- "Ghosts" from previous marriages can haunt new families through contact with ex-spouses, visiting children, ex-inlaws, old friends, and the like. Entanglements from previous marriages, such as financial settlements and custody arrangements, may affect the functioning of the remarriage family. Psychological and emotional detritus can also be a factor by inhibiting a new spouse from being able to trust, commit, and have realistic expectations for the new marriage. In addition to healing, a complete psychological and emotional divorce should occur before a new marriage is considered.

- Pre- or antenuptial agreements can be a valuable step if prepared through a process of mutual dialogue. It does not necessarily have to be a legal document or procedure; however, stating goals and expectations for marriage may be useful for partners in all areas, including finances.

- In remarriage families, adults must tend to the needs of children from previous marriages and preserve ties with them even though there can be a temptation to be very involved with the new marriage. For the remarriage couple, it is important to establish a foundation (environmental *and* emotional) for the marriage before acquiring a family.

- Sexual attraction between step-family members (except, of course, the marriage partners) can lead to "pseudo-incest," which can be devastating for the whole family.

- In-laws, holidays, and handling finances are important areas for consideration by remarriage families. Changes in financial management should parallel changes in family-systems transaction patterns.

- It is crucial for children to retain their biological ties within the remarriage family unit. Each partner's commitment to his or her children must be balanced with the commitment to the new spouse.

- The therapist should be able to differentiate clinical issues and syndromes from remarriage issues.

Introduction

The number of remarriage families has increased rapidly in the past several decades—and continues to do so today. It is currently estimated that one in five American families with children under the age of 18 (over 5 million families) is a remarriage family. **These complex families are entering therapy in increasing numbers, and it behooves clinicians to understand their different formations, dynamics, and functioning.** In addition, because remarriage families (Sager et al., 1983) are so varied in structure, goals, and the issues and symptoms they present, the therapist needs a broad theoretical lens to encompass the kaleidoscopic fragments these patient families attempt to combine into a cohesive unit. Therefore, the **clinician should have a wide range of treatment strategies at his or her command for the different situations that may arise.**

This lesson addresses the many terms used to designate remarriage families, the various important components of these families, and frequent themes in the problems and issues they present. A case example (that may be considered typical) is presented, and intervention strategies to be used when warranted are presented.

Although there are many documented difficulties that remarriage families may confront, **approximately 83% of divorced men and 75% of divorced women choose to remarry; approximately half of these marriages end in divorce.** The odds may seem overwhelmingly stacked against the happiness and longevity of remarriage families because those whom we see clinically and upon whom much of the available data is based (Goldner, 1982; Kaslow, 1988; Sager, Brown, Crohn, Engel, Rodstein, & Walker, 1982) are distressed and involved in negative cycles of interaction. **Knowing how to intervene effectively can reverse the negativity, hostility, and pessimistic outlook of some families**, and decrease the odds that they will need to divorce.

Terminology

It is difficult to find a term in the English language that accurately depicts the remarriage family. Many people, such as Visher and Visher (1979), prefer the designation "stepfamily." Yet, for others, this term conjures up visions of the "wicked stepmother," about whom children learn from fairy tales. They dread this person as a result of an early distorted exposure to the term and its negative symbolism. In addition, "step" seems to connote "one step removed," which may imply a barrier to the establishment of a close relationship. **Unfortunately, the myth of the wicked stepmother persists and seems to create a scenario for a "self-fulfilling prophecy"** in that children may anticipate their father's new bride will be nasty, cruel, demanding, and rude (Kaslow, 1988); as a consequence, the children may relate to her based on this expectation rather than on her actual personality and behavior.

"Reconstituted" or "recoupled" are words favored by others. However, the dictionary definition of "reconstitute" is, "To restore to a former condition" (Webster, 1983, p. 984). "Recouple" denotes a similar meaning. These terms are thus inaccurate, because the marriage of two people, at least one of whom has been previously wed to someone else, constitutes the establishment of a new relationship rather than a return to an earlier condition.

Likewise, numerous problems arise from the designation "blended family." Blending entails mixing together so that the constituent parts become unrecognizable. It is important in remarriage families for the prior parent-child(ren)-grandparent constellation to maintain its special ties and earlier history so that this identity is not lost or camouflaged. **The new family may attempt to act as if the other biological or adoptive parent never existed so that the new family can become more cohesive. Living in such an artificial world is virtually always detrimental to children, as it is predicated on decep-**

tion and obscures one's roots (Boszormenyi-Nagy & Spark, 1973, 1984). The idea of blending, although often well-intentioned, can cause some children to have a diminished sense of self, a lack of clarity about their heritage, and a loss of contact with the nonresidential biological parent (Ahrons & Rodgers, 1987; Sapasnok, 1983). Therefore, blending should be avoided except under very extreme, compelling circumstances.

The term "remarriage" literally implies a situation in which divorced spouses reunite. However, to this author, it seems to be the best option, because it conveys both that a marriage has occurred and that it is not an original union. Nonetheless, when most applicable and to avoid repetition, the other terms elucidated above will be used interchangeably as synonyms in this lesson, as is done in much of the current literature. A more accurate term for this varied and complex family form will hopefully be coined in the future.

Family Composition

Although each remarriage family is unique, all remarriage families share some characteristics (Kaslow, 1988). Indeed, these families are intriguing in their complexity and diversity.

If first marriages are hard to define and depict, remarriages are even more complicated. Many possible pairings exist:

- Both partners previously married and divorced; neither has children
- Both previously married and divorced; each has children
- Both previously married; one has children from the prior marriage
- Both previously married (one divorced, one widowed); each has children from the previous marriage
- One previously married and has children one never married
- One previously married and has children; one unmarried with an out-of-wedlock child
- One unmarried with no children; one divorced with children
- Both widowed; each has children

Precursors to the Remarriage

Entrance into the new marriage may be accompanied by uninvited "ghosts from the past." This includes ex-spouses who call or send messages, children who were not expected to "live in" or visit often, ex-inlaws, old friends, and even bill collectors. The fantasy that they will vanish or fade away is rarely realized: They are alive and influential—and must be dealt with.

Unresolved items from the earlier marriage, such as a lingering sense of pained rejection and rage, almost always exist. There are often financial entanglements with the former mate that remain until all child and spousal support payments end. The economic divorce from the former mate (Bohannan, 1970; Kaslow, 1990) is not coterminus with the legal divorce; rather, it continues until the last amount of money that is to be sent by the payor to the recipient ex-spouse is made. **Frequently, connection with the past extends beyond this period as both parents remain involved in supporting their children. This may stir up or keep alive earlier dissension and hostility, which can spill over into the second family in numerous ways.** (See case study and discussion of themes.)

Many people who engage in remarriages have been badly wounded and see themselves as having failed. Although they may not like being without a partner, they do not want to risk another painful parting that culminates in divorce. **Also, if the person believes or knows with certainty that the former mate betrayed him or her by having an affair and/or lying about money or other important matters, he or she is apt to have difficulty trusting a spouse again. Generally, if someone has effective therapy during and/or after the divorce, and allows ample time for the healing to occur** (Kaslow &

Schwartz, 1987; Kessler, 1975; Wallerstein & Kelly, 1980), **then the psychic divorce will be accomplished and the person will be more ready and able to invest emotionally in a new, committed relationship** (Kaslow, in press). Putting one's life in order and feeling confident and optimistic again—even when one is quite emotionally healthy—usually takes 2-5 years after the physical separation has occurred. Thus **it is rarely a good idea for a person to remarry soon after a marriage is terminated, before he or she deals with the sense of failure and the need to prove his or her attractiveness and desirability.**

In light of the often-devastating impact of divorce on adults and their children, many people are reluctant to make a total commitment to a new marriage. In addition, it is typical for those contemplating second and/or third marriages to have amassed some assets, and they wish to protect them from becoming "marital property" on the day of the wedding. This prospect looms menacingly to those who feel that they lost too much in their previous divorce and who fear another divorce or the advent of death and the channeling of assets to their new spouse's family instead of their own. **Such valid concerns have led to increasing usage of prenuptial** agreements (Dreyfus, 1990) **and, more recently, postnuptial agreements, which elucidate the financial arrangements that the two parties are willing to make with one another** (Du Canto, 1991).

Because such documents often tend to be formulated by the wealthier member of the potential couple with his or her attorney, they may be used to intimidate and control. At times, there is an overt or covert threat that one spouse will cancel the wedding if the other does not sign. When this occurs several weeks prior to a scheduled wedding, the party receiving this document and the accompanying declaration may be astonished and disconcerted at their seeming lack of recourse. **Trust** (or **lack thereof) may surface as an issue and threaten the upcoming marriage**; yet, surprisingly, few people alter their plans at this point.

Pre- or antenuptial agreements become a blueprint for the marriage and can be valuable if prepared through a process of mutual dialogue. I suggest to clients that they first evolve a "psychosocial prenuptial accord" (Kaslow, 1991). This is done by discussing, over a period of several weeks to several months, what each partner wants and needs in the relationship, what each is prepared to offer (Sager, 1976), and which wants or needs the other has that they cannot or do not wish to fulfill. Such honesty and integrity in making one's attitudes known to the other fosters the building of a mutually open and respectful relationship. It enables each to honor comfortably the commitments previously made to an ex-spouse and/or children both verbally and in the divorce agreement. Once they understand why they are marrying again, and why they have chosen each other, they can proceed to negotiate the financial issues so that the prenuptial agreement facilitates the creation of the type of marriage they desire. From such discussion they can create a fair plan (with or without the aid of a skilled therapist), and then one of them can have his or her lawyer draft the plan—preferably in easily understandable language with minimal "legalese." Once crafted, the other takes the plan to separate legal counsel for fine-tuning. Such a process is noncontentious, empowering, and growth oriented (Kaslow, 1991). Once this agreement is signed, the couple can proceed into the new marriage with a more informed picture of the pleasures and possible pitfalls that lie ahead. Romance can flourish more fully in an atmosphere pervaded by truth.

The following case analysis and discussion of the treatment process will highlight some of the typical dilemmas that remarriage families confront. Certainly not every concern confronted by remarriage families was expressed by the family being discussed, nor do all blended families exhibit all of this family's problems.

The following case represents an illustration of a remarriage family that is a composite of many we have treated at the Florida Couples and Family Institute in Palm Beach County from 1981–1993.

Case Study

Bill called to ask that I see him and Gail, his spouse of 4 months. He was distressed because he discerned that his choice of a second wife was an error and wanted help in deciding whether to try to improve his turbulent marriage or to end it quickly and "cut" his and his children's pain and discouragement.

In the initial interview, Bill, a 40-year-old administrator in a mid-sized hospital chain, presented as a fastidious, attractive, and highly controlled person. His voice was calm; he seemed rational, articulate, and pleasant. Gail, the wife, was a 33-year old nurse's aide in the same organization. She was somewhat untidy, highly reactive, tense, and anxious. They appeared mismatched, or the embodiment of "opposites attract." Bill had an MPH degree from a well-regarded university; Gail had a high school diploma equivalent. He seemed to be "classy" and upwardly mobile; she appeared to be from a lower socioeconomic background and to have a dependent and angry personality. All of her energy went into "just keeping her head above water."

The summary of their relationship history during the first few sessions indicated that they had met at work and been almost immediately attracted to each other. Gail was previously divorced and had custody of her 10-year-old daughter. She and her daughter, Kyle, had reluctantly moved back to Gail's parents' home—from which she had run away 16 years earlier because she could not tolerate her parents' abuse. Both parents still were alcoholics and lived a squalid existence.

When Gail ran away, she took menial jobs to support herself and then "married the first man who proposed." He turned out to be physically abusive, and Gail sought relief in drugs and alcohol. She had an affair with a drug dealer to obtain drugs and money. Two years before she came to my office for marital therapy, Gail mustered enough courage to leave her husband and file for divorce—despite his strong protests. Her family called her a deserter but let her move back home. Three months after their divorce, her ex-husband committed suicide. His suicide note blamed her for deceiving and abandoning him and for stealing Kyle. Both families (hers and her ex-husband's) blamed her. Gail felt bewildered, horrified, and terribly guilty. Her ex-husband's death was a subject she could not discuss with Kyle; it was therefore shrouded in mystery. Despite the fact that, after her divorce, Gail had become a licensed practical nurse, her earnings were too meager to provide for Kyle and herself. She detested living with her parents, as she found their drinking and quarreling obnoxious. When she met Bill at work, they "fell for each other." Hearing her desperate need to move from her parents' home, Bill's sympathies were aroused, as was his ardor. He invited her and Kyle to move in with him temporarily. Gail considered herself lucky and appreciatively accepted his offer.

When they first met, Bill had been divorced for approximately 1½ years. He had primary custody of his 11-year-old daughter, Suzy, and his 15-year-old son, Greg. He was an involved, devoted father; the three of them were a close and interdependent trio. Greg and Suzy resented the intrusive entry of Gail and Kyle into their lives. Because they adored their father, they placed all their blame on "that seductive witch." By the time Bill and Gail arrived at my office for therapy, they had been married almost a year, and resentments had intensified.

Gail's substance abuse escalated after she moved in. The children often saw her "under the influence." She became sloppy and did few of the homemaking tasks. Bill's ex-wife, Tina, sought a change of primary residence because she did not want her children living with "that drunken whore." Bill, an empathic rescuer, captivated by Gail's helplessness and wanton charm, was unable to ask her to leave. Tina gained custody of the children and he projected all blame for this loss onto Gail. He insisted that Gail enter a residential treatment program, which she did for 1 month. While she was there, Bill cared for Kyle and saw his own children frequently. The two girls became friendly and began to regard each other as sisters. Bill was relieved that some benefit was being derived from the relationship.

When Gail was discharged, her prognosis was deemed "cautiously optimistic." Her reentry into the pseudo-family put everyone on guard, as the three children and Bill feared her volatility and a possible relapse. Because she desperately wanted to marry her lover and protector, and because Bill was still fascinated by her beauty and sexiness, he agreed to wed if she promised to stay clean, be receptive to his children, and go to work steadily. Bill, governed by his compassion, married her after 1 month of sobriety. His children were furious and felt as if he had spurned them in favor of Gail.

Because Bill was lenient with Greg and Suzy, partially to appease his guilt, they rarely adhered to the set visitation times. Both of his children had rooms at his marital home—Greg had his own room, and Suzy shared one with Kyle—they visited and left whenever they desired. Whereas Gail needed the structure of a visitation schedule to feel safe and in charge, Bill wanted flexibility so he could see the children whenever they were available. His indulgence of their whims unnerved Gail and played havoc with her tenuous recovery program.

The children's dissatisfaction with Gail contributed to the escalation of the marital conflict. Bill finally called to enter therapy. Gail wanted the marriage to continue, but wasn't confident. She was a month short of a year of sobriety and was proud of her progress. Her success afforded me an area in which to affirm her determination and her growth. But her lifelong emptiness was so acute that she needed to possess Bill totally and felt competitive with his children—and even Kyle—for his attention. When thwarted, she became uncontrollably angry and further alienated everyone; Bill was embarrassed by her outbursts. The more he gave, the more she seemed to require. Like many spouses of a "borderline personality" (American Psychiatric Association, 1987), he realized that "he never could give enough" to satisfy and appease her. He could no longer tolerate her jealous attacks when he wanted to spend time alone, such as hiking or playing golf with his son on the weekend. Meanwhile, she felt that he undermined her recovery by insisting she prepare special dinners on the nights his children came to visit—even if this interfered with her attendance at a Narcotics Anonymous (NA) or Alcoholics Anonymous (AA) meeting. He refused to go to Al-Anon, as he saw the addiction as her problem—not his—and did not want to be further "sucked into" the substance abuse/recovery world.

The couple also quarreled over money. Gail resented his generosity to Greg and Suzy; he felt she overindulged Kyle and did not contribute her salary to the household budget. Bill regretted having married "beneath his level" and thought his wife might inadvertently block his chances for rapid career advancement. Even though she still "turned him on," he was ashamed of her. He was ambivalent about staying married and was often cool to Gail, which provoked her wrath.

Themes in Treating the Remarriage Family

CHILDREN PREDATE THE MARRIAGE:

In the aforementioned case, as in many remarriage families, children existed before the "remarriage" and were an integral part of their parents' lives. Bill's and Gail's special bonds with their respective children following their divorces had become stronger. This often occurs as they support each other during the mourning period and try to fill the void in each other's lives. Sometimes they cling together simply to survive the upheaval. When a live-in relationship occurs, the warm, close-knit parent-child unit is often overshadowed by the passionate intensity of the new love relationship. **The delightful intimacy of a one-on-one adult psychosexual adventure causes the parent-child ties to recede from prominence—fostering resentment in bewildered children who once again feel abandoned.** Because their stability had again been disrupted, it is not surprising that Greg and Suzy, who lost their beloved father as a primary residential parent to "her," resented Gail. Her arrival into their home led to their return to their mother's house and a significant loss of Dad's daily caretaking. To his children, Gail personified "the wicked stepmother." Meanwhile, Kyle acquired an intelligent and nurturing father, a nicer, more solid home, and a much-wanted sister. Bill and Gail had never had a chance to live alone together and become acclimated to one another; **they had not established a foundation for the marriage before acquiring a family,** and the relationship was strained because they lacked a shared history.

GHOSTS FROM THE PAST AND PERSISTENT RIVALRIES:

Unfinished issues from prior marriages often haunt the stepfamily. In this case, Bill's first wife petitioned successfully to become the primary residential parent of Greg and Suzy. She periodically called Bill to reemphasize the children's criticisms of Gail and to disparage her as a "wanton whore." Not wanting to further antagonize her and risk additional alienation of his children, Bill swallowed her criticisms and permitted total flexibility regarding visitation. His attitude and behavior enraged Gail and interfered with her efforts to bring calm and structure into her chaotic life.

Meanwhile, Gail was haunted by guilt over insisting on her divorce, thereby deserting her ex-husband, and perhaps having ignited his suicidal demise. These were the accusations hurled at her by her own family. Whenever she spoke to them, they degraded her. In addition, her unwillingness to discuss honestly Kyle's father's death with Kyle prevented the establishment of a trusting relationship.

The unwanted presence of both former partners in Bill's and Gail's thoughts exacerbated the ongoing tensions and heightened competition between Bill's first and second wife. The first wife had not remarried, and, despite her periodic antagonistic behavior, she wanted to reunite with Bill. **Ex-husbands often remarry before their ex-wives do, and a similar pattern ensues; the two wives establish an uneasy truce because they share a husband (albeit sequentially), children, and money. Sometimes open warfare ensues, making the establishment of a happy marriage virtually impossible.**

MONEY—THE UNFINISHED FINANCIAL ASPECT OF DIVORCE:

The economic divorce only ends simultaneously with the legal divorce (Bohannon, 1970; Kaslow & Schwartz, 1987) **when the marriage has been short-lived, there are no children, and the financial settlement is completed at the time that the divorce decree is issued.** Ordinarily, child support continues (as it usually should) as part of post-divorce parenting, at least until the youngest child is 18 years old, and often until completion of post-secondary school and beyond. Many divorced persons desire to continue to help provide for their children and give them a good start into young adulthood. However, **it is not unusual for a second spouse to resent the outflow of funds and/or feel deprived of what he or she wants. Moreover, the second spouse may have been led to believe he or she would receive the funds for himself or herself and the new family,** especially when there is insufficient money for everyone involved and/or if this person has a very empty/

needy/jealous personality. In light of the fact that sending money is a frequent, repetitive, court-mandated occurrence, the disgruntlement is periodic—if not continuous. Every time the ex-spouse or children overtly ask or subtly convey the desire for more, it may put pressure on the relationship of the remarriage couple. All of these factors were present in the case presented. At the time they began therapy, Greg was attending a local community college and his father had volunteered to pay for his tuition and books. Gail admonished Bill for "wasting our money on your lazy, stupid, ungrateful son." Having had to fend for herself, she believed that if Greg wanted to go to college, he should earn the money and pay his own way. Because Kyle expressed no interest in attending college, Gail was not worried about setting a precedent that would adversely effect her daughter.

When long-term alimony payments have been imposed by a judge, even if fully warranted, the seemingly permanent economic encumbrance often enrages a second wife (or husband, if the wife is the payor). She may be unable to comprehend: (1) Why he should keep supporting "her" when he gets nothing in return except aggravation (usually, she doesn't want him to get anything positive in return); (2) why the ex-wife can refrain from working due to the amount of child *and* spousal support her husband sends, while she has to work so they have enough income; (3) how he can say "no" to her when she or her child wants or needs something (including more time and attention) but he must either succumb to the ex-wife's demands or be summoned back to court (Kaslow, 1988). Such conflicts of interest do not create a context for harmonious living in many blended families; it certainly did not in the case of Bill and Gail. Gail grudgingly worked because of financial necessity; she harbored no desire to express herself through a career. Her disdain for the idle and seemingly pampered former wife of her husband was always simmering, just as it is in other remarriage families.

FOCUS ON ANNOYING BEHAVIORS AND TRAITS:

All the unresolved emotional "baggage" a person carries is brought into the new marriage. Some couples are mature and wise enough not to allow small things to disturb them, as they do not wish to hurt each other or the relationship. Pettiness was often a major source of tension in their earlier marriages, so they try to be accepting and tolerant. But **the minute annoyances accumulate over time, particularly when time alone together is scarce, and many disagreements surface regarding handling and being with (or away from) the children.**

Gail disliked Greg's "vegging out" silently and alone behind closed doors in his room. She detested his liberty to come and go without a schedule. She disliked Suzy's challenging manner and her "sassy" retorts. Gail expected obedience and compliance from Bill's arrogant teenagers; they wanted her to "quit nagging." His submission to his ex-wife's and children's demands, combined with his critical tirades about her earlier addictive behavior and her increasing rigidity about his children's actions, were chronic irritants to her. Bill disdained her need to take part in an AA program and treated her as inferior and sick. The threads that held their recent marriage together were precariously strung; this is frequently true of the remarriage families who present for treatment, because they find it hard to tolerate each other and/or their partner's offspring.

SEXUALITY AND SEXUAL ATTRACTIONS—INCEST IN THE STEPFAMILY:

The taboos against mother-son, brother-sister, or father-daughter sexual relationships are not as definitive in remarriage families as they are in nuclear families (Phipps, 1986). An adolescent stepsister and stepbrother may appeal to each other enormously, particularly in the atmosphere of heightened sexuality that may initially infuse a blended-family home when Mom and Dad are overtly very much in love. Inadvertently, the new parent couple may facilitate this by evincing great pleasure and relief at how much the two teenagers like each other and by encouraging them to do things together. If the teenagers are left home alone together and impulsively or deliberately become "lovers," they are then faced with living with their tantalizing and disturbing secret, or revealing their sexual involvement and causing their parents enormous consternation. If the daughter becomes pregnant, it wreaks havoc in the family. When one loses interest in the other, they must still live together and face the actuality and memory of what has transpired. So, **although this may be only "pseudo-incest," the consequences can be devastating** (Fuller, 1993), **and the situation needs to be avoided.**

Similarly, the mother may be pleased that her new husband likes her daughter and is willing to coach her in playing sports, driving a car, or learning geometry. She may be grateful for the affection they develop for each other, never suspecting that her daughter has become her competitor for her husband's sexual, not parental, attentions. Although this theme was not present in the case study, it appears often enough to merit mention as a major issue.

THE LACK OF ANYTHING THAT IS "OURS":

When couples remarry, often one or both already have their own residence. There may be a dispute over whose home to keep and whose to sell or lease. **Regardless of which one keeps their abode, the newcomer who moves in is apt to feel like an interloper;** he or she must take over closet and drawer space previously used by others. Frequently, the new arrival will want to bring along some personal possessions or redecorate, so that the house will partly reflect his or her personality and spirit. When this does not occur, the newcomer generally feels like an unwelcome outsider. Yet when he or she does imprint the existing home with his or her personal touches, **prior residents may feel like they are being disregarded and intruded upon.** Clearly, this was part of the resentment Bill, Suzy, and Greg felt when Gail and Kyle moved in, mainly because space that heretofore accommodated three people now had to accommodate five.

Whenever possible, couples in a new union should create a *new* shared environment that belongs to *this* marriage, and that affords it a sheltering context in which to flourish. This may mean placing emotional considerations above financial ones and selling both separate properties to purchase a new one jointly. If this is not financially feasible, then the couple should, by agreement, make ample changes so that both feel that the home is theirs. Possessions each has acquired should be pooled and some of each person's should be used. If any item is closely associated (in the minds of the children or one of the adults) with a former spouse, it should be replaced so as not to keep memories alive. For example, children are alarmed when Mom's new husband comes to sleep in "Dad's bed." Therefore, at a minimum, the bedroom should be refurnished.

However, **children who reside in the house should be allowed to keep their rooms as they were, if they so desire, and to keep pictures of their other biological parent on display, as this person is important to them.** The new step-parent may be uncomfortable with this, but should honor the child's identity, parentage, and preferences. If not, they will initiate a no-win battle.

OTHER PREVALENT THEMES:

Other prominent issues include dealing with in-laws, deciding where children are to spend holidays, and handling finances. Generally, it seems to this author that a "yours, mine, and ours" system of accounts works best to preserve the sense of individuality and independence, while also substantiating the commitment to the marriage. Sound and sensitive financial planning that accounts for separate and shared interests is recommended highly (Moreau, 1993). Therapists can suggest this, as **changes in financial management can and should parallel changes in family systems transaction patterns.**

The Course of Treatment

PHASE I:

The first phase of treatment with the case-study family consisted of two history-taking sessions, in which each partner constructed a genogram in my office to promote spontaneous discussion about the significant people who populated their complicated family tree, and their feelings toward them (Kaslow, 1986; McGoldrick & Gerson, 1985). This graphic family portrait provided us with a depiction of who "belonged to" and responded to whom. **Many mixed emotions and bittersweet memories arose in this process, fostering some ventilation and catharsis.**

I inquired whether they had discussed their expectations of each other and of the relationship before deciding to marry. They had not done so then, nor since that time. Therefore, **three sessions were used for exploration of: (1) What they wished for and craved; (2) what they were willing to give to the other; and (3) what expectations they did not think they were capable of fulfilling.** This contracting process (Sager et al., 1982) helped them articulate why they had chosen one another, what needs were and were not being met, and **their current—as opposed to their earlier—emotional state. By shifting their focus to the here-and-now, they were unfrozen from their stagnant positions**—Bill from continuing to criticize her about her substance abuse and rudeness to his children, she from nagging him about his preference for his children over her and his indifference to her wishes, particularly for time alone together. By the third session, Gail decided to go to at least one AA meeting for week. Bill finally agreed to go to Al-Anon a minimum of once each month. Both acknowledged that she had done well in staying sober and that this was to remain a major objective. Bill's long-overdue recognition of her "clean time" was valuable to her, and I was able to convey to him the urgency of his accepting that she had moved beyond her "drunken whore" stage and was living a sober and respectable existence. It was suggested that he talk to Greg and Suzy about acknowledging Gail's changed behavior and that he urge them to stop treating her like an unsavory "slut." In grateful response, Gail volunteered that she would stop nagging Greg about his room and try to be more flexible about visitation. They designated at least one night per weekend to go out as an adult couple—with friends, or alone—and Gail tried fervently to keep her impulsivity and temper under control by such actions as using self-imposed time outs and jogging when she felt like yelling.

PHASE II:

Once a better homeostasis was established between Bill and Gail, a double session was held with both of them and the three children. To the family's astonishment, Gail was able to listen attentively and not react defensively. Kyle looked young for her age, and was giggly and shy. She seemed to have copied her mother's pattern of not dealing with emotionally charged issues. However, Suzy responded to issues such as: what it felt like when Gail and Kyle moved in; when she and her brother had to return to live with their mother; when Gail went to the hospital for treatment; and when her father decided to marry Gail. Her disillusionment with her father and her rage at and dislike of Gail were revealed rapidly. Despite her sadness, sense of loss, rejection, and bewilderment at her father's actions, a bright, responsible, and candid adolescent emerged. I commented upon her admirable truthfulness. Then, Greg, who had maintained an aloof presence, entered the dialogue. He initially stated that his father's actions had not mattered to him, and that his dad had a right to do whatever he wanted. He then added that he was becoming fond of Gail, because she had stopped "drinking and drugging," and expressed a willingness to be more cooperative. He was pleased that their expectations had been clarified, and asked that they address his concerns about college, a career, and what support he could count on from them. Bill stated that he would support him, just as he would have if the original marriage had not been dissolved. Gail became visibly but quietly distraught at Bill's additional financial pledge to his son, especially if he were to attend college, which would have resulted in room-and-board expenses. This issue needed continued processing in phase III of treatment with this couple, just as recurring **disagreements about expenditures** do for many remarried families. **These problems are more complex in remarried families than in first-time couples because of divided loyalties.**

Greg and Suzy both emphasized that they wanted to spend time *alone* with their father on weekend visits, that he was aware of this, and that Gail was jealous when he did. They were angry at Gail's resistance and protests. We discussed the validity of their respective desires and the **importance of each set of *biological ties* within the remarriage family unit.** Trembling, Gail told of her fear that Bill and his children would form too tight an alliance from which she and Kyle would be extruded. She revealed her worries about the children poisoning Bill's attitude towards her again, and persuading him to desert her.

After everyone had their say on this perplexing issue, it was agreed that Bill could spend part of each Saturday that the children visited alone with them. In addition, they all decided that Friday evening was to be "family night," and Bill and Gail would go out as a couple on Saturday night. Although Gail was uneasy with this plan, she agreed to try it for a month in return for the children promising not to complain about her to Bill, but to try to talk with her directly and politely when they had something to straighten out. Nevertheless, Gail's starvation for nurturing still caused her to feel uneasy at the thought of sharing Bill in this way.

As in most remarriage families, **the commitment to one's own children must be balanced with the commitment to one's new spouse** (Kaslow, 1988); **and this often necessitates structuring time so that there is "something for everybody."**

PHASE III:

In succeeding sessions, attention was focused on other ways Gail could try to fill her inner emptiness, such as participating in AA; acquiring a sponsor; enjoying time with Kyle while Bill was busy with his children (something she had never done); making friends whose company she might enjoy; and asking Bill to devote some time and positive energy to her exclusively throughout each week when she would be an interesting and fun companion/wife/lover.

Sometimes I hold family-of-origin sessions with each of the spouses in the remarriage couple and their respective parents and siblings to help them recapture and rework unresolved issues from the past that are impacting negatively on their current lives (Framo, 1981). However, this seemed counterindicated in this case. Both Bill and Gail believed that Gail's efforts to repair her relationship with her parents and become a respected adult in her original family had only resulted in their ridiculing her for becoming "Miss prim and proper," and thinking she had become too fancy for their family. Being in their company, she said, led her to regress.

In this stage, some of the therapeutic dialogue focused on Bill's passive controlling machinations, his extreme permissiveness with his children, and his ambivalence about wanting to be in the relationship, which blocked his ability to achieve closeness and intimacy with Gail. Whereas some people enter a remarriage believing that they should do all they can to make the marriage work, Bill fell more within the other group of persons who think, "If I don't like it, I can leave," and, "The second divorce has to be easier than the first."

The therapist's role combined multidirectional partiality (Boszormenyi-Nagy & Spark, 1973, 1984) **in the attentive listening, and, in the circular questioning, clarification and interpretation, confrontation, provocative and paradoxical comments, behavioral suggestions, restructuring, ego support, and questions regarding where the couple wanted to be 1–3 years into the future.** Although the primary modality was **couples therapy from a family systems perspective to strengthen the parent/spouse unit, individual sessions were held with each spouse as needed.** In phase III, the treatment format included one family session per month so that the entire remarriage family had an opportunity to engage in productive interchange and resolution of troubling issues. **As they conversed in the format of the therapeutic conversation and dealt with the anger through ventilation, apologies, and forgiveness, they were able to bond more closely into a compatible unit. This approach emanates from the "diaclectic" or integrative model of Kaslow** (1981).

An effort was made to dispel the myth of the "wicked stepmother," a role into which Gail had been cast and had initially fit well. **Two other destructive myths** also were explored, dissected, and seemingly eradicated: **(1) That there should be instant love, affection, and respect between members of the recently created remarriage family** (Einstein, 1982); and **(2) that "ghosts from the past" would vanish, never to be seen or heard from again.**

Remarriage families should be helped to understand that **loving bonds only evolve over time** and when a sense of humor prevails. They must also accept the fact that **former spouses and in-laws, as well as one's own parents, are alive and will reappear**, asking for something, making unwanted statements, and perhaps deliberately trying to cause turbulence. Children who are not in residence will also call and visit. **The real issue is not how to make them vanish, but how to cope with them most effectively and exercise some choice on the nature of the present relationship. These myths are apt to surface in the treatment of most remarriage families and must be dispensed in order to make substantial progress.**

Unresolved mourning regarding the ending of the prior marriage must be completed before enough psychic energy and trust are available to invest deeply in a new commitment. Power and control issues often burst forth, as they did with the case study. **After having the couple address the power imbalance and their respective needs for control, therapy may use a psychoeducational model to teach them how to develop effective problem solving techniques to use when future battles for control erupt.** Only then do conflict-ridden remarriage families have a good prognosis for their "third chance" families to co-evolve well and to live reasonably satisfying lives together. **Family conferences for planning and problem resolution should ultimately replace therapy sessions** (Kaslow, 1988).

Summary

When treating remarriage families, it is important to recognize that people enter second or third marriages with high hopes and much caution. They harbor their unfulfilled dreams from the past and bring much "excess baggage." **The therapist, in formulating his or her systemic hypothesis, must be able to differentiate the clinical issues and syndromes** (such as Gail's substance abuse disorder and extreme dependency) **from step issues** (such as children's resistance to and sabotage of a parent's new partner and love interest). Therapists who are not conversant with the existential realities and core dynamics of the establishment of blended families may find themselves searching for the right clinical diagnosis for one or several family members that label the difficulty. In reality, **the ways in which reconstituted families deal with the special dilemmas created by their step structure is predicated upon both intrapsychic distress *and* difficulties that create a new, close system of family relationships following the pain and chaos of divorce or the death of a parent/spouse.** All of these become intertwined issues, meriting attention in therapy.

In addition, **personal issues and dysfunction can heighten the marital dissension and make the process of building a new life together more difficult.** For example, when an adult who was imbedded in a family triangle as a child becomes a step-parent through marriage to a rebellious biological parent, they are likely to recapitulate their insider-outsider experiences. **It is essential that those treating remarriage couples help them understand how the stepfamily structure initially contributes to a high level of stress for all, and that this situation is quite normal.**

If the adults' new relationship with each other began before either or both were divorced, resentment by the children is apt to be extremely strong, and will be harder to overcome, as this is a transgression many children of all ages find almost impossible to forgive. (In such cases, therapy is even more complex, and space allotted does not permit elucidating the treatment protocol that I use.)

With efforts at cooperation made by everyone, including patience, tolerance, and the ability to perceive and laugh at the absurdity inherent in this extended family form, the remarriage family can flourish and succeed, particularly when the individual members also accept responsibility for their own growth and development.

This lesson has attempted to distill the essence of the remarriage family—looking at and differentiating the personal/clinical from the stepfamily issues they present. **Cautious optimism has been expressed about the viability of the majority of remarriage families, providing they are highly motivated to make their amalgamated unions happy and satisfying for *all* members.**

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QUESTIONS BASED ON THIS LESSON

9. The author prefers to use the term "remarriage" because:

   A. It suggests that constituent parts of the family are unrecognizable

   B. It does not imply that divorced spouses have reunited

   C. It suggests that the marriage is not an original union

   D. None of the above

10. According to the author, which of the following facts regarding remarriage is *false*?

    A. Wives generally remarry before their ex-spouses

    B. Prenuptial agreements are sometimes used by the wealthier partner as a power device

    C. Half of remarriages end in divorce

    D. The economic divorce often occurs after the legal divorce

11. In phase I of treating a remarriage family, the author:

    A. Holds a double session with each partner as well as with their children

    B. Conducts two history-taking sessions

    C. Holds family-of-origin sessions with each of the remarried spouses and their respective parents and siblings

    D. Avoids having the partners discuss their expectations

12. According to the author, which of the following is *not* a myth of remarriage families?

    A. The stepmother often mistreats her stepchildren

    B. Loving bonds among members of a remarriage family evolve over time

    C. Love and affection should develop quickly among the new family members

    D. "Ghosts" from the past are generally not bothersome after the remarriage

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Directions in
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VOLUME 1 • LESSON 4

Working with Families Headed by Single Fathers

Geoffrey L. Greif, DSW

Dr. Greif is Associate Professor, School of Social Work, University of Maryland at Baltimore.

KEY POINTS

- Recent data show that single fathers are raising more than 2 million children in the United States today.
- The increasing number of single fathers can be attributed to the women's movement, the increased expectation that women should have careers, a profound shift in the court system's view of women, and an expression of interest in raising children by fathers.
- Challenges facing single fathers include: few role models; fathers tend to be isolated and not included in parenting discussions to the same extent as women; fathers are praised for being good fathers while, paradoxically, they are also regarded as being less competent than women as parents.
- Child care is a major concern for single fathers. Child care is most difficult to find for children in the 7–11-year-old range. Research found day care and out-of-home sitters to be most satisfactory.
- Although housework does not seem to be a problem for single fathers, daughters assist in doing housework more than sons.
- In general, older fathers and those involved with child care before a separation, divorce, or death, those who obtain custody after a court contest, and those with social support from friends and family tend to make the adjustment to single fatherhood better than others.
- Resolving the relationship with ex-wives is very important. If the divorced parents have an amicable relationship, both the child(ren) and the father seem to benefit. A combative relationship between parents is detrimental to children. The most damaging effect seems to be caused by a sporadic involvement in the children's lives by the mother. Consistent absence or regular presence of the mother is the best option.
- Therapists working with single fathers should try to:

  Normalize the experience for their clients

  Teach fathers how to delegate household chores to children

  Help fathers balance child care and work

  Teach fathers how to handle children's feelings

  Provide support to fathers who are socializing again after a long time

  Help fathers determine to what extent the ex-wife should be included in therapy

  Refer clients to support services

Introduction

The last 20 years have witnessed an explosion in the number of fathers raising children alone following separation and divorce. Whereas there were 393,000 single male heads of households raising at least one child under 18 alone in 1970, the number tripled to 1,351,000 by 1990, with less than 10% of these fathers being widowers (U.S. Department of Commerce, 1990). Recent data show this trend to be continuing with these **fathers, who raise more than 2 million children** (U.S. Department of Commerce, 1992).

Gaining an understanding of this type of single-parent family is important for three reasons: **(1) As the number of these families increases, they represent a more substantial portion of the single-parent landscape and an increasingly viable form of custody; (2) these fathers can teach us more about fathering in general; and (3) mental health professionals may increasingly be treating the fathers and their children, thereby necessitating their having a psychological framework with which to work** (Greif, in press).

The reasons for the increase in single-father–headed families are many. Chief among them has been the burgeoning **women's movement,** which has **opened up numerous options for women.** With greater access to the workplace, women no longer necessarily have to stay in a marriage for financial reasons. Generally, **women are free (and in fact encouraged) to find fulfillment through work rather than primarily through motherhood.** The simultaneous trend toward greater equality for women in the workplace has precipitated a profound **shift in the view of women in the court system.** As custody cases are being decided less frequently on the basis of gender, **the presumption that a child's primary caretaker should be female has been weakened.**

One consequence has been the **increase in joint or shared custody. The increased frequency of this arrangement, which presumes that both parents should be involved with child rearing after a marital breakup, has moved the courts closer to affirming the benefits of having fathers participate actively in the child's development.** An additional significant reason for the increase in awarding sole custody to fathers is that **many fathers are expressing a greater interest in raising children than before** and believe they can win custody in court.

What happens then to single fathers when they gain custody of their children following a separation, divorce, or death? To understand them, we first must examine who they are and then some of the major tasks with which they are confronted.

Characteristics of Single-Parent Fathers

Fathers who gain custody of their child(ren) come from a variety of backgrounds. Indeed, they are of every class, religion, and occupation. This represents a change from 20 years ago, when fathers who raised their children (often middle- or upper-class men) were generally regarded either as making a political statement (as a reaction to the women's movement) or as living in extraordinary circumstances in which the mother was absent. As a consequence, it was more difficult at that time for fathers to gain sole custody.

Although the research into the lives of these fathers tends to draw from those of the middle- and upper-classes (who seem to be more apt to participate in requests for surveys), a comprehensive examination of their demographic characteristics shows that **this population also includes fathers with lower incomes.** In fact, one analysis states that **20% of these men receive some income maintenance assistance** (Meyer & Garasky, 1993). Fathers, perhaps contrary to popular belief that they only raise older boys, do raise girls and very young children as well (Meyer & Garasky, 1993). However, the **underrepresentation of persons of color in the descrip-**

tive studies may hinder an accurate demographic analysis at this time.

One significant finding of these surveys has been the identification of **key differences between single fathers and single mothers**, though it is impossible to determine definitively whether single parent childrearing is harder or easier for men than women. On average, **women earn significantly less than men**; this is confirmed when single mothers are compared with single fathers. In addition, **although single mothers are not generally afforded any special treatment when they gain custody, men often report they are.**

On the other hand, one difficulty that single fathers currently encounter is a **paucity of role models**. Though this situation may be ameliorated as more fathers are awarded sole custody of their children, as recognition is increasingly forthcoming from the community, and as support groups for single fathers become more numerous, **fathers do tend to be isolated and are not included in parenting discussions to the same extent as women.**

Finally, fathers tend to receive conflicting messages about their role—**they are praised on the one hand for being caring fathers while, on the other hand, they are usually regarded as less competent than women** (Greif, 1990). The response to them is often, "You are wonderful for raising your children alone—but you must be getting help from your mother or sister. Men really can't do this on their own." Though these comments are often well-intentioned, fathers tend to respond to this reaction as an insult to their parenting abilities.

The Tasks of Parenting

The various tasks of single fatherhood that fathers generally face every day in their home and work circumstances include:

- **Dealing with housework and child care**
- **Balancing work and child care**
- **Coping with the emotions of children**
- **Starting a social life**
- **Resolving the ongoing relationship with an ex-wife**
- **Navigating through the court system**

Each of these areas is discussed at length below.

DEALING WITH CHILD CARE AND HOUSEWORK:

Every parent, whether single or married, male or female, must, at some point, make child care arrangements for young children. Single-parent fathers are no exception. **Finding child care has proven to be a major concern across several studies of single fathers** (Bartz & Witcher, 1978; Chang & Deinard, 1982). **Because the vast majority of fathers in these studies were working outside of the home and living without any other adults in the home, day care and sitters for young children were used extensively, with relatives used less often.**

The problems posed by children vary by age. **Arranging child care is the most difficult for fathers with children in the 7–11-year-old range because of the temptation to leave them on their own when they may not be prepared for such independence.** Younger children clearly need child care, and older ones can be left on their own (Greif, 1985*a*). **Day care and out-of-home sitters are more satisfactory than in-home situations in some families because there tends to be more consistency in the adults providing care** (Mendes, 1976). **Time management** (having enough time for the children) has also been reported as a problem for the fathers (Chang & Deinard, 1982).

With occasional exceptions, **fathers seem to have few problems handling housekeeping**, and they rarely hire housekeepers (Risman, 1986; Bartz & Witcher, 1978; Gasser & Taylor, 1976). Men appear to adjust to housework following an initial period of confusion. **Some share their housework with their children while others**

report feeling it is important to handle the chores on their own as a way of proving their competence to others. One study of the division of chores within the single-father home found that **children helped out more as they aged and that daughters assisted more than sons** (Greif, 1985*b*). At the same time, a number of fathers admitted that the house did not look as neat as it did when their wives were still living in the home. This is most likely due to men traditionally not placing as much emphasis on the appearance of the home as women have.

BALANCING WORK AND CHILD CARE:

One of the more difficult areas for single fathers is **balancing work and child care. Because men have traditionally defined themselves by their career, a father who must divert his attention from work to child-care demands may suffer an identity crisis.** Many fathers, when married, leave the care of the children to their wives (who also often work, though in a lower paying job). At that time, their self-concept is often derived mainly from their career success.

When such fathers are awarded sole custody, they must adapt to becoming the children's primary caretaker. **Because they are usually unable to concentrate on work to the same extent they had prior to the divorce or death of a spouse,** their career often suffers as a direct result of their divided attention. They cannot as easily assume an overtime assignment, travel, or take a client to dinner. Over 80% of single-parent fathers reported that working while rearing a child was "difficult" or "very difficult." **Although coworkers were generally perceived as supportive of the single father, supervisors are not always as helpful.** One study found that **some fathers quit their jobs when they become sole custodians, and a handful were fired. Self-employed fathers seemed to experience the least amount of employment-related complications** (Greif, 1990).

One recent analysis of the careers of single fathers identified several **characteristics that seemed to facilitate balancing work and child care. Older fathers, those who had been involved in child care before a breakup, those who had obtained custody after a court contest,** and **those with sufficient social support from friends and family, tended to make the transition to single fatherhood more successfully** (DeMaris, Greif, & Hood, in press). Some problems identified in this study include: **taking time from work to deal with child-care issues; being unclear how to handle telephone calls from their children while at work; the need to attend after-school events; and the transportation of children to a doctor's appointment.** However, **others seemed to welcome the opportunity** to limit the pressures of career ambitions and concentrate on their children's needs.

DEALING WITH CHILDREN'S EMOTIONS:

Can fathers handle the diverse emotions their children display? What about fathers raising daughters alone? According to more than 15 years of research on these fathers, **single fathers report feeling quite comfortable raising their children.** Observations of these fathers and their children tend to confirm this assertion (Greif, 1990). Research on children raised by single mothers and single fathers, while varying in its results throughout the years, tends to support the parenting abilities of fathers. **Few clear discrepancies have been found in the functioning of children raised by mothers and children raised by fathers.** One comprehensive analysis of data indicates that **no significant differences exist between boys and girls raised by the same-sex parent** (Downey & Powell, 1993).

Fathers tend to give themselves satisfactory ratings as fathers and to be satisfied with how their children were developing in most areas of their lives. The research does show that **a minority of fathers experience difficul-**

ties with their children and that raising children alone has improved their relationship with their children (Greif, 1985*a*).

However, daughters pose a unique challenge for many men. Anecdotal reports show some fathers being unclear how to handle **discussions of female development, shopping, and role modeling. They tend to use their own mothers, sisters, teachers, and friends to deal with these areas.** But although daughters pose challenges to these fathers, they also can fulfill parenting needs. In one study, **fathers who were raising preadolescent daughters reported the greatest satisfaction with the parent-child relationship**, when compared with fathers raising children in other age ranges. The reason was thought to be a **special bond that daughters often form with fathers before they (the daughters) reach puberty** (DeMaris & Greif, 1992).

As mentioned earlier, **these daughters sometimes come to occupy a unique position in the home in terms of the kind of housework and child responsibilities they assume.** Although it may be believed that fathers in these nontraditional families would tend to treat their children in nontraditional ways, the opposite is the case. **One study reports that daughters do more housework than sons.** This may be caused by either a continuation of the role they were playing when the mother was in the home, with the daughters seeking these tasks so they feel worthwhile, and/or others encouraging them to assist their fathers (Greif, 1985*b*).

STARTING A SOCIAL LIFE:

Following the breakup of a marriage or the death of a spouse, many fathers wait a number of months before they start dating again; **the typical father waits about 6 months. When they do begin relationships with other women, it is with some frequency, but not with a great deal of satisfaction.** In one study, almost half the fathers reported dating once a week or more with another quarter dating once or twice a month. Yet **the majority reported dissatisfaction with their social lives** (Greif, 1990).

In divorces that result in custody being awarded to the father, it is more often the wife who has initiated the dissolution of the marriage (Greif, 1985*a*). As a result, the father is typically "gun shy" of new involvements. **When he does resume dating, it is usually after being out of the social scene for many years.** Because the expectations for men and women's dating behaviors have undergone continuous change over the last few decades, he may be unclear how assertive to be, whether to pay for the date, and how to react to being asked out by the woman. With perhaps a more limited income than when he was single, **the single father may find himself unable to entertain in the manner to which he was accustomed.** If he wants to entertain in his home when the children are present, he may find it impossible to serve a romantic dinner while, for instance, the children are watching television in the next room.

The father has to manage more than his own discomfort when he resumes socializing. **One reason children may initially refuse to accept their father's socializing is that it dashes any hope that their parents will reunite.** This may manifest itself as specific complaints about the father's choice in dates. As children perceive an unpopular relationship as becoming more serious, they may threaten to move in with their mother if such an arrangement is possible.

The new woman involved with the father may also be in a delicate position. She may be unclear whether she is being sought after as a friend, potential mother to the children, a future wife to the father, or as a transition object to help the father cope with the loss of his marriage. The father will often be unclear himself about what he is seeking, but **will tend to place the needs of the children above those of the woman**, thereby placing her in a more precarious position.

It is notable that many fathers do remarry. Those who do not remarry and have difficulty in accepting their potential long-term single status may be most in need of psychological services.

RESOLVING THE RELATIONSHIP WITH THE EX-WIFE:

Single fathers must work on resolving their relationship with their ex-wives and finalizing the legal proceedings that are often involved in custody and child-support disputes. Even though the marital relationship has ended, single parents have to work out the continuing coparental relationship for the benefit of the children. **When the father and mother have divorced on good terms and are continuing to have an amicable relationship, the children and the father appear to benefit.** This is especially true if the father views the mother as a competent parent, a view that is unfortunately rare (Greif, 1985*a*). **Conversely, if the father and mother are battling and using the children as pawns, everyone suffers.**

The most damaging element in this scenario seems to occur if the mother's involvement is sporadic rather than consistent. Fathers report that they have the easiest time establishing a satisfying relationship with their children when the children's mother visits either frequently or not at all. If visitation is occasional and unpredictable, the relationships tend to be unsettled and the father has difficulty preparing himself and the children (Greif & DeMaris, 1990).

NAVIGATING THE COURT SYSTEM:

When court experiences of single-parent fathers are compared with those of single-parent mothers, **the fathers' complaints tend to be stronger, their stories of financial problems more significant, and their worry about losing custody more fervent.** While the majority usually have gained custody without a court battle, those that do go to court may frequently have to spend thousands of dollars to gain and retain custody. Even though they have "won" in court, they often see the process as being biased against men. **Many worry that, because of this bias, their ex-wives will be able to find a sympathetic judge and reverse the custody arrangement. However, data reveals that this occurs infrequently** (Greif, 1987).

Child support is rarely awarded to fathers and, when it is, the chances of collecting the full amount owed are worse than the chances of a single mother collecting from an absentee father (Meyer & Garasky, 1993). In addition, the amounts awarded to fathers tend to be lower, due in large part to the lower income of the noncustodial mother. **Some fathers do not even seek child support, feeling that if they supported their wives during the marriage, there is no reason to be supported by them afterward.**

Therapeutic Considerations

When counseling the single father with custody, it is important to keep several principles in mind:

- Because the time pressures on single fathers (like single mothers) may be stringent, **a short-term approach may be the most efficacious.**
- It is important to **accept and understand single-parent fathers' nontraditional position in society. These men often feel as if they have no role models.** They need to hear that the practitioner appreciates the potentially uncomfortable situation in which fathers find themselves.
- To facilitate their growth, **the fathers may need to have their experiences normalized.** This can be undertaken by a therapist who is knowledgeable about some of the tasks (described above) with which the father may be struggling. **Employing a teaching role about these tasks, as well as about the expected developmental stages for children, can be reassuring.**

- **Fathers who are struggling with housework may need permission from the family therapist to delegate chores appropriately to the children.** Some fathers exonerate children from having to do anything around the house as a way of dealing with their own guilt about the departure of the mother. A more appropriate approach is to **include the children in daily chores and to guard against overburdening daughters.**
- **If child care is required, the father may need help in ascertaining the extent to which children can or cannot be left on their own, how outside child-care workers can be interviewed, and under what circumstances he can be called at work. Clear guidelines in this area can allow the father to focus on his own work when away from his children.**
- For the father who is **suffering a blow to his self-esteem** because of work and home conflicts, **directly addressing the conflict and perhaps exploring family-of-origin issues can be helpful.** The messages the father received about work when he was growing up may factor into the current situation.
- **Fathers tend to struggle with how to handle their children's feelings.** They tend to believe that discussions about the divorce or death need to be brought up only once or twice before they are settled. The therapist can teach the father that **feelings change as the children grow and that the children will benefit by ongoing opportunities for discussion as each new developmental stage raises anew the need to talk.**
- In the area of socializing, it is important to **support the father, when he is ready, to go out with friends or dates. Needlessly staying home sends a message to the children that they, in turn, should not be with friends—a message that is potentially damaging. If the father has not already told his children he will be dating at some point in the future and that such action is a normal part of moving on with one's life, he should be encouraged to do so.** This normalizes the event so the children are not taken by surprise by his dating.
- **Consideration must be given to the pros and cons of including the ex-wife in the therapy sessions with or without the children. One danger of inclusion is that it resurrects the children's fantasies of their parents' reconciliation.** In addition, **including the mother with the other family members may heighten the volatility of the situation.** On the other hand, **not including her may preclude important systemic information from being gathered.** The best course is to **make an assessment of the father and his family first and, if warranted, interview the mother by telephone** before making a decision about her inclusion.
- **Other services such as supportive legal counsel and support groups for the fathers may be helpful.** The former will help the father to feel that his rights are being protected, whereas the latter will provide a forum for learning how other single parents are coping with their situations.

Conclusion

The single-father–headed family has, in many situtations, proven itself to be a viable alternative to the more common single-mother family. As the numbers of these families increase, mental health practitioners will increasingly be called upon to treat these fathers and their children. **Understanding the issues faced by single-parent fathers as they move into nontraditional roles is instrumental in helping them and their children cope with the challenges and rewards of family life.**

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QUESTIONS BASED ON THIS LESSON

13. Which of the following statements is correct?

A. In 1990, just under 400,000 single male heads of household were raising at least one child under 18

B. The increased frequency of shared-custody arrangements demonstrates that the courts still overwhelmingly favor mothers over fathers

C. A short-term approach for single-parent fathers may be the most effective due to time pressures on these men

D. When counseling single-parent fathers, there is no need to normalize their experiences

14. Major challenges facing a single-parent father include all of the following *except*:

A. Dealing with housework and child care

B. Starting a social life

C. Navigating the court system

D. Raising children who are inevitably more emotionally deprived than those raised by mothers

15. In a recent study, DeMaris, Greif, and Hood identified all but which of the following problems encountered by single-parent fathers?

A. Being unclear how to handle calls from children at work

B. Obligations to attend after-school events

C. Complete lack of confidence in disciplining their children

D. Balancing work ambitions and family responsibilities

16. According to the author, the most damaging scenario in a divorce situation is one in which:

A. The mother's involvement is sporadic

B. The mother and father battle, thereby using the children as pawns

C. The mother visits the children frequently

D. The mother does not visit at all

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VOLUME 1 • LESSON 5

The Role of Family-Treatment Approaches in Adolescent Substance Abuse

William H. Quinn, PhD

Dr. Quinn is Associate Professor, Marriage and Family Program, Department of Child and Family Development, University of Georgia, Athens, GA.

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KEY POINTS

- Family life is a salient treatment variable with substance-abusing adolescents. An individualistic focus on child and adolescent behavior often unfortunately excludes the family.

- Drug use is a means of separating from the family. If autonomy is attempted in this way, and if there is no reconciliation with the family, the adolescent most likely will search for identity in a group of peers who are experiencing the same (or similar) type of family dysfunction.

- Substance use provides the adolescent with a sense of belonging to a peer group while removing himself or herself from authority, emotional numbness, thrill-seeking behavior to tempt fate, and reflecting feelings of immortality or hopelessness.

- Families of drug abusers, who tend to perceive themselves as useless, tend to exhibit conflict and rigid, outmoded patterns of operation. In fact, substance abuse is associated with family disruptions and transitions.

- Substance abuse can be used as a metaphor for emotional problems. Drug abusers typically have limited social involvements. They have a disproportionate number of parents who are substance abusers; their siblings also tend to abuse drugs.

- Family therapy can be more effective in curbing adolescent drug abuse than adolescent group therapy or family education; accordingly, parents and adult family members should participate in intervention. Family treatment should include assessment of parental substance abuse and origin of family conflicts. Home detoxification programs are successful in which parents monitor the drug abuser out of school. Family psychotherapy should be part of intensive inpatient treatment. Outpatient therapy should be frequent, with continous family therapy.

Introduction

> *Our young people seem now to love luxury. They have bad manners and contempt for authority. They show disrespect for adults and spend their time hanging around places gossiping about one another. They are ready to contradict their parents, monopolize the conversation in company, eat gluttonously, and tyrannize their teachers.*
>
> —Socrates

The adult perception of adolescent behavior as a break in social norms is hardly a 20th-century phenomenon. However, more recent concerns regarding adolescent functioning and well-being are unique in many ways, and should be seriously considered by therapists who deal with this age group.

Adolescents in a Contemporary Context

In the 1940s, the major school problems reported to the national committee on schools were gum chewing, rude behavior, and walking in the halls during classes. **In the 1980s and 1990s, the major school problems reported are violence and drug abuse.** In 1992, at a conference organized by the Carnegie Council on Adolescent Development entitled "Crossroads: Critical Choices for the Development of Healthy Adolescents," Joseph Califano (1992) stated:

> In this day, adolescence is a decade of life marked by the confusions rampant in our society between libertarianism and liberty, materialism and morality, peer pressure and parental guidance, and by a social and economic revolution that has given most adolescents absentee families, generations of parents and grandparents separated by geography, divorce, and irresponsibility.

The Carnegie conference concluded that there are progressively more adolescents younger than age 15 who experiment with illegal drugs and consume alcoholic beverages regularly (often five or more drinks in a session).

Furthermore, Antonia Novello, then U.S. Surgeon General, reported that of the nation's 20.7 million students in 7th through 12th grades, 8 million drank alcohol monthly and 454,000 have five or more consecutive drinks at least once a week (Califano, 1992). Many of these adolescents "are already alcoholics and the rest may be on the way." Of these individuals, 41% are female. Furthermore, a study by the Institute of Social Research at the University of Michigan reported that of 73,000 high-school seniors, 40% of white students and 29% of black students reported use of marijuana within the past year. Cocaine use was reported by 12% of white boys and 6% of black boys. The report takes issue with the influence of the media, but it unfortunately virtually ignores the role of the family. Yet **there is significant evidence, as well as common agreement, that the family is a salient treatment variable** (Huberty & Huberty, 1986; Kaufmann, 1979).

ADOLESCENTS AND THE FAMILY UNIT:

Although peers are significant to the development of adolescents, **the family remains crucial to a young person's well-being** (Eccles et al., 1993; Quinn, Newfield, & Protinsky, 1985). Family life with adolescents is a misunderstood phase in the evolutionary cycle of events that underlie stability and change in social groups; **it is a time of what anthropologist Victor Turner** (1969) **calls "social drama."** He defines a social drama as "a unit of aharmonic or disharmonic social process arising in conflict situations."

The social drama contains four elements—all of which are affected directly by adolescent drug behavior:

- **A breach of predictability governing social relations between persons within a social system** (in this case, the family)
- **A phase of mounting crisis moving toward a visible cleavage in these relations**; this periodic bickering, or sparring, is normal and inevitable across cultures and primate groups

- **A regressive action operationalized in response to a concern to limit the spread of crisis;** this is conducted by prominent members of a disturbed social group (in this case, the parents)
- **A "reintegration" of the disorganized social group and a "legitimation" of the irreparable schism between the contesting parties.** (A number of events and altered views might occur that contribute to a reconciliation in time, such as leaving home successfully, undergoing psychotherapy, gaining or losing a family member, forcing a shift in roles, or recognizing new information about another family member. Several family process characteristics symbolize these four dimensions of the social drama and form the basis of a treatment model that builds upon the therapeutic implications of the drama.)

The breach of a crucial norm in adolescent-family social relations is the break in an agreement between parents and the adolescent that a dominant-submissive dichotomy be accepted. This break is a temporal shift, which is stimulated by the developmental changes of adolescents. Such a breach must essentially be either blatant disobediance or an obvious nonfulfillment of some crucial norm. Generally, adolescents actively violate these norms.

Drug Behavior and Family Systems

The individualistic focus on child behavior (including the drug abuse) often has excluded an important phenomenon—the family (Minuchin, 1985). Although the family provides a context for the developing child, it simultaneously incurs transformations via the participation of the child. Considering the family life cycle, the marital life of the parents, and the current life circumstances (financial resources, housing, educational circumstances, and health status) of the adolescent and family, some adolescents are at higher risk of developing problems than others. **Yet the reconciliation of problematic life circumstances is the process by which such life stressors are managed adequately.**

Some family systems lack a process or context in which to allow for reconciliation. In the case of drug behavior, this risk may be a function of interpersonal conflict and often may be driven by the premise that "alcohol and other drug abuse by an adolescent is an act having interpersonal consequences and must be seen in its social context rather than being narrowly defined as a matter of biology" (Todd & Selekman, 1991). Unfortunately, **taking drugs is a seemingly useful mechanism of action because it injects a powerful message into the informational channels of families.** Therefore, drug behavior represents a symbolic trigger for confrontation.

It is unfortunate and destructive that this breach cannot be addressed in less harmful ways in families. Some families are unable to acknowledge breaches in patterns of communication and thought that promote adolescent autonomy; however, at the same time, an adolescent naturally desires a sense of belonging to a group. **Without a family resource, adolescents are forced to seek a sense of belonging on the streets with peers who may be embedded in similar family dysfunction.**

THE ROLE OF ADOLESCENCE:

There is a scarcity of rites of passage in adolescence (Quinn, et al., 1985). It was suggested that the social relevance of adolescence is vague and confusing—if not meaningless—in cultural context. Adolescence is a byproduct of industrialization in which the economic value of youths essentially has evaporated; instead, it is shaped by their value to those who prey on their consumer-laden tendencies or, perhaps, their boredom or constraints that prevent them from participating in the useful side of life. For adolescents, an eagerness to be perceived as physically mature definitely exists. Yet they desire to maintain a somewhat carefree existence, without significant responsibility, as if to say, "I want to be in the world, but don't expect me to know how to be part of it."

For many in contemporary society, the adolescent experience partly consists of abrasive interactions with authority (such as parents and teachers) and partly of an overcompensating peer group, which attempts to counter strife and add meaning to turmoil. These relationships are normal because physiologic, emotional, and social changes confuse identity and role clarity. **One way adolescents counter these unresolved interactional conflicts with adults is to take drugs. In doing so, they achieve a sense of belonging with peers and an emotional numbness to compensate for the emotional alienation or conflict in the family. Drug taking may also be a manifestation of thrill-seeking behavior to tempt fate for immediate pleasure, reflecting the adolescent's sense of immortality or feelings of hopelessness stemming from a deprived environment.**

This social drama does not necessarily lead to a physical separation (although runaways, street gangs, and homeless youth represent that possibility). However, the drama does involve a **negotiation or reconstruction of roles, thereby representing the changing goals of the social group**. For the adolescent, a changing goal is a push for autonomy; independence in thought and emotion as well as physical separation. However, some families are unable to move beyond the mounting crisis; they cannot suggest an appropriate alternative to keep the group together. **A successful countermove by parents, incidently, should not be an adamant push to return to prior family patterns.**

The following examples describe family dysfunction with drug-involved adolescents:

- An 18-year-old male adolescent was a heavy drug user in the hope that he would be such a worrisome problem that his divorced parents of 5 years would reunite, though his father had remarried. In this particular case, we recommended that the parents participate in treatment with their son and his 23-year-old sibling.
- A 15-year-old girl abused drugs because she was smothered by a set of overbearing parents. The mother would remind her to clean her room each day to remove the dust so her allergies would not flare up, although her daughter contended that her allergies only flared up when her mother failed to make regular appointments with the allergist. The mother reminded her constantly to eat vegetables and checked the level of cleanliness of her daughter's bathroom daily. When a therapist requested that the mother take a brief "vacation" from parenting and the father take over, the daughter came home one night inebriated; her mother found her asleep with wet clothes from the rain and guided her in removing them. None of these actions on their own might be considered inappropriate but, taken collectively, they reflect the family's denial of this social drama. Add to this scenario the father's passive support for this desperate need to control his daughter's behavior and his punitive stance toward her attempts for self-control; this family is stuck in outmoded and rigid interactions that stifle growth and development.
- In another case, a daughter and single-parent mother took drugs together to help the mother soothe her grief about her marital breakup and loneliness. This intergenerational pattern of alcohol and drug use in the family is well known. Recent data suggest that more young children are using drugs, possibly indicating the effects of drug use on siblings and these children's pleas at a young age for help (Califano, 1992).

Families that exhibit evidence of adolescent drug abuse are overrepresented with characteristics of developmentally outmoded, often-rigid patterns of operation. The family ecology contains interactional patterns that do not allow the members to satisfy individual needs or establish acceptable distance-regulating mechanisms to rectify these breaches. Furthermore, they do not demonstrate effective shared-group experiences to tie members together in a meaningful way.

TRAITS OF FAMILIES WITH ADOLESCENT DRUG ABUSERS:

Studies and clinical observations of families of adolescent drug abusers have yielded the following conclusions:

- **Adolescent substance abusers are overrepresented in families with extreme family conflict** (i.e., hostility or apathy in marital relations, bitterness and ineffective divorce adjustment between divorced parents, or disturbing interaction between the adolescent and one or both parents).
- **Substance abuse is associated with family disruption and transitions** (i.e., divorce, death, or remarriage and the subsequent adjustment to a stepparent). Adolescents are vulnerable to these disruptions because their abilities to express their feelings honestly, confusion, and grief with effective responses from other family members often are limited. Furthermore, some parents fail to acknowledge or modify the consequences of adding further instability to an adolescent's already unstable universe.
- Family rituals or rites of passage are nonexistent or limited (Quinn, et al., 1985). There are few visible markers to confirm or validate adolescent competencies and associated responsibilities and privileges. For instance, some adolescents consider driving a car to be an achievement for surviving adolescence, rather than a privilege to accompany their sense of responsibility. **Some drug-abusing adolescents perceive themselves as useless, because they have few experiences of success at home, at school, or in the community.** Therefore, they behave below their creative levels and full potential. It is much rarer for adults in society to expect too much from adolescents as opposed to too little. There are many false claims in society regarding the incompetence of youth; such claims culminate in paternalism (Quadry, Fischhoff, & Davis, 1992) and a view of teens as unable to govern their own actions or make significant contributions to their social context. (In a case of a 14-year-old adolescent who abused drugs and whose single parent mother had been diagnosed with degenerative joint disease, the youth was directed to apply his woodworking interest and skills by building a ramp for his mother to enter the house more easily.)
- **Parental relations are conflictual and, therefore, ineffective in managing or remedying their child's substance abuse.**
- **Substance abuse is associated with emotional problems and serves as a metaphor for these problems.** Typical nonverbalized statements representative of incongruent family roles and counterproductive family environments include: "I don't feel wanted/significant here in this family"; "I am worried about your grief"; "I am tense or anxious with your new husband/wife in the house with me"; "I am confused about how to grow up"; "How can you make me stop my drug abuse when you abuse yourself?"; and "You hypocrite!"
- **Substance abusers have limited social involvements** (i.e., extracurricular activities or peer involvements with adolescents who do not abuse drugs). Parents tolerate or even condone an adolescent's inactivity or passive involvements, such as excessive use of television or video games. Parental life stressors intrude on the desire of parents to initiate interaction or physical activity with adolescents. The adage "no news is good news" is too often a mindset of anxious and personally troubled parents.
- **Adolescent substance abusers have a disproportionate number of parents who also are substance abusers.** This results from acquiescence or modeling and the parents' demonstration of similar maladjustments in their own development. In effect, such parents provide little guidance related to coping with hardship or disappointment. Therefore, these adolescents view adversity as intolerable rather than integrative to life experience.
- **Families of adolescent substance abusers are not unlike families with other adolescent problems with regard to intensity of conflict, occurrences of family transitions or disruptions, outmoded or inflexible interactional patterns, or a dearth of family rituals or rites of passage.** Clinical data indicate that families being treated for different adolescent-presenting problems demonstrate similar dysfunctional characteristics (Reilly, 1984).

THE ROLE OF PARENTS:

Criminologists report that the "war on drugs" attacks the problem from the wrong angle (Gottfredson & Hirschi, 1989). To them, parents—not the police—are the key to the drug crisis. Their research indicates that drug abusers are not any different in profile from those who perform other criminal acts and that **children who are taught to respect the property of others, to delay gratifications of the moment if they conflict with long-term goals, and to understand the negative consequences of drug and alcohol abuse are less likely to abuse drugs or commit criminal acts regardless of the strength of the criminal justice system.**

It is no coincidence that **siblings of drug-abusing adolescents are also more prone to substance abuse**; they belong to the same families who have susceptible characteristics. One study of family therapy with adolescent substance abusers who had been arrested showed that they were significantly less likely to be arrested again for any crime, including drug-related events, than adolescents who did not receive family treatment (Linne, 1984).

A severe limitation in intervention is the view that families are not important to health care. Families often have been neglected by treatment centers, researchers, and policy makers. Modern health care, including mental health in the 20th century, has centered upon a tradition of individualism, with the primary obligation placed on the status of the individual. If a secondary obligation exists, it relates not to the family but to the public health of the community (including disease transmission and the well-being of political agenda). **If substance-abuse disorders are transmitted frequently through families environmentally** (two thirds of alcoholic individuals do not have a family history, and children of alcoholics are likely to be younger when first intoxicated than children of nonalcoholic parents [Bennet, Wolin, Reiss, & Teitelbaum, 1987]), **prevention and intervention efforts logically should include the family.**

A more recent problem is the modest or lukewarm attention directed to families of adolescents in treatment. The family is used as a "parole board" by which members are "informed" about the adolescent's problems and health progress, rather than as a contributing part of the problem and the solution. Given the description of family influences in adolescent substance abuse, it seems clear that families should play a more vital role. **Family members should be active ingredients in any intervention, and, more important, in any prevention.**

A Family Treatment Model

Treatment or intervention programs for adolescent substance abuse should require family participation (during or after detoxification if necessary). Family therapy can be a more effective treatment in curbing adolescent drug abuse than adolescent group therapy or family education (Joanning, Quinn, Thomas, & Mullen, 1992). The family should not be a group to which treatment providers simply report the status of the adolescent's progress, but an active participant in solving the problem. Intervention requires an understanding of the larger system. Sometimes, this involves even more than the family, such as schools or the court system.

Parents and/or other adults (i.e., grown siblings or grandparents) in the family should be required to participate routinely in intervention. Programs for adolescent substance abuse should not ignore the family, because the adolescent ultimately will return to the family environment. Without family participation, treatment success frequently disappears after the adolescent is discharged from therapy. Furthermore, **family treatment should include an assessment of parental substance abuse and the origin of family conflicts.**

Families must be engaged in treatment to supervise adolescent substance-abuse patterns. We have had success with a "home detoxification" program in which

parents are obligated to supervise the adolescent when he or she is not in school and to ensure that schools monitor nonsubstance abuse behavior (Quinn, Kuehl, Thomas, Joanning, 1988). This is particularly crucial because inpatient treatment must be of a limited duration, given the financial constraints of families and health-insurance limitations. If constant supervision is perceived to be necessary for constraining drug behavior, and family members are unable or unwilling to do so, an off-duty security guard or college student may be a more cost-effective alternative than inpatient facilities. We have found these options, as well as the use of the court system, to be effective.

The traditional once-a-week psychotherapy sessions should not be the staple of treatment. When necessary, inpatient treatment should include family therapy several times per week. Outpatient family therapy, which some insurance companies are now encouraging, should be more frequent and include a multiple-family format when possible. Other research studies indicate that outpatient treatment and partial hospitalization can be as effective as inpatient hospitalization at significantly lower cost.

Just as parents and siblings are crucial to treatment, **schools are essential to continued success.** Schools require drug-free behavior, although they are not always successful. The dilemma is that social control can be antithetical to adolescent treatment, because to suspend or dispel students is to strip away their normal environment. We must be cautious about using institutions primarily for social control for long periods. Furthermore, **a family's financial well-being** (Anmis, 1986) **and future plans** (i.e., college tuition and medical care) **must be protected. Flexible solutions must be discovered with school assistance to protect the adolescent's necessary resources for future success.**

Marital relationships, family rituals, rites of passage, sibling development, and inappropriate family roles (e.g., the effects of a recent gain or loss of a family member) must be foci of treatment. It is important to identify the available resources to alter the family transactional patterns in a way that is beneficial to the adolescent and that improves the life situations of other family members as well.

Family approaches to adolescent therapy are valid treatment models because they contain a prevention focus. Siblings who may be vulnerable to substance abuse and mental health disorders—as well as to the family as a group—may benefit from the effects of treatment on family processes, which may deter potential crises in the future. **Family treatment is also preventive because it can limit the possibility of relapse.**

The model presented in Table 1 serves as a blueprint for family treatment in cases of substance abuse, and it contains elements of structural therapy (Minuchin & Fishman, 1981) and strategic therapy (Haley, 1987). Three stages are delineated with an approximate number of sessions indicated for each stage. This number varies due to the level of family motivation, the complexity of problems, and the level of family resources. **The model is structured so that the initial phase is focused directly on the drug behavior due to possible risks to physical well-being, threatened status in school, and potential negative legal outcomes. Family goals are established, woven into the initial phase of treatment, and brought to the fore in stages II and III** (Quinn, Kuehl, Thomas, Joanning, & Newfield, 1989).

Conclusion

When asked about the most important improvement needed in adolescent substance abuse treatment, many treatment providers and colleagues answer without hesi-

Table 1
FAMILY SYSTEMS THERAPY

Family Goals	*Contextual Goals*	*Therapist Activity*
Stage I (1–5 sessions)		
Adolescent drug-free behavior	Therapist-family relationship	Joining—accommodation Nonblaming—positive connotation Convening strategies
Adolescent involvement	Parental coalition	Coaxing negotiation of rules Significant relatives or cotherapist in single-parent families
Stage II (5–9 sessions)		
Eliminating parental drug abuse **and/or**	Open split—familial discord	Unbalancing—raising intensity Enactment—changing reality Complimentarity Identifying strengths
Marital harmony **and/or** Conflict-resolution skills	Balancing marital power Contracting with parental identified patient above	Opening conversational space
Stage III (9–12 sessions):		
Developmental shifts (separation)	Constructing rites of passage	Prescribing rituals Pairing adolescent achievement w/status and privilege Family role negotiation
Networking	Sparking competencies	
Sibling strengths	Engaging extra-familial systems	Prescribing community attachment

tation, "More family involvement." However, some treatment providers do not consider family involvement essential and, in fact, passively accept the family's apathy or fear of active participation. Can an adolescent be treated without being present in treatment? **Intervention personnel must *demand* such inclusion in policy making and program development. Otherwise, the ability of therapists to bring about drug-free behavior will be limited.**

Based on various research findings, individual treatment as the primary intervention for the adolescent substance abuser cannot be responsibly justified. **I believe that it is not possible to reduce significantly the number of adolescent substance abusers without the family's participation. Promoting a "reintegration" of separately connected adolescents in a family system may help to make substance abuse unnecessary.**

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QUESTIONS BASED ON THIS LESSON

17. The Carnegie Council on Adolescent Development:

A. Identified four elements that comprise the "social drama" of substance abuse

B. Reported that 8 million of the nation's 20.7 million students in 7th through 12th grades drank on a monthly basis

C. Failed to establish a link between substance abuse and family disruption

D. Found that progressively more adolescents under age 15 are experimenting with illegal drugs regularly

18. With regard to the family treatment model, the author advocates that:

A. Parents should be encouraged, but not required, to take part in adolescent drug abuse therapy

B. The focus of treatment should be the adolescent's weekly psychotherapy sessions

C. Family goals should be discussed only in stage III

D. Inpatient treatment should include family therapy several times per week when necessary

19. Which of the following does *not* characterize stage I of the author's blueprint for family systems therapy?

A. Home detoxification

B. Involvement of significant relatives

C. Constructing rites of passage

D. Forming a parental coalition

20. Which of the following statements about adolescent drug abuse is *true*?

A. Families that exhibit evidence of adolescent drug abuse are underrepresented with characteristics of often-rigid patterns of operation

B. Adolescent substance abusers rarely have parents who are substance abusers

C. Substance abusers tend to have a limited social life

D. The intensity of conflict in families with adolescent substance abusers is significantly greater than in families with other problems

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Directions in Marriage and Family Therapy

VOLUME 1 • LESSON 6

Parent Training for Children with Attention Deficit Hyperactivity Disorder

Robert F. Newby, PhD, ABPP

Dr. Newby, a child neuropsychologist, is Associate Professor of Neurology, Medical College of Wisconsin, Milwaukee, WI.

VOL. 1

NO. 6

KEY POINTS

- Symptoms of attention deficit hyperactivity disorder (ADHD) include: inattention, impulsivity, and motor restlessness. The two best treatment approaches are behavior management and medication.

- Parent training serves the need for specific guided practice in behavior management. Clinicians conducting parent training for ADHD should be familiar with three definitions of the disorder—the first is developmental, the second is based on specific diagnostic criteria, and the third incorporates ideas prevalent in current research.

- Most parent training concentrates on behavior management of childrens' problems with non-compliance and poor rule-governed behavior. Children who also have prominent internalizing comorbid problems would be served best by individual or family psychotherapy supplemented by parent training.

- During parent training, a diagnostic assessment should be conducted (of child, family, and environment). The assessment can include interviews, clinical observations, observations in natural environments, parent- and teacher-completed behavior rating questionnaires and psychological testing.

- Treatment goals include: increasing parents' knowledge of causes of children's behavior problems; improving parents' ability to manage these problems; and increasing children's compliance. The *modus operandi* of achieving these goals is based on parents' delivering immediate, specific, and consistent consequences to children's positive and negative behaviors.

- Format of treatment is flexible, and it can be delivered in both the individual (tutorial) and group settings.

- Two crucial areas of parent training are building parent-child rapport and enhancing parents' attending skills. The results: parents enjoy a renewed sense of connection with their children, and children regain pleasure in receiving their parents' attention.

- Behavior modification systems such as token economies are useful for supporting positive behaviors. Used consistently, time-outs are effective punitive measures for negative behaviors.

Introduction

Attention deficit hyperactivity disorder (ADHD), one of the most common problems facing mental health professionals who work with children today, affects approximately 5% of the school-aged population. Because the **major symptoms—inattention, impulsivity, and motor restlessness**—usually persist to some degree throughout childhood and adolescence despite treatment (Fischer, Barkley, Edelbrock, & Smallish, 1990), effective treatment for this disorder attempts to manage or ameliorate symptoms rather than to cure the core problems.

Behavior management and medication are two treatment approaches that appear to have the most reliable impact on ADHD symptoms. Behavior management involves a broad set of methods such as **structuring the physical environment, delivering commands, and planning behavioral consequences,** with the goal of attaining what Barkley (1990) terms a "prosthetic social environment" in which to contain and direct ADHD symptoms. In order to have a significant impact in a given setting (such as home or school), behavior management methods must be applied directly and continuously in each environment. Stimulant medication can provide varying degrees of benefit for approximately three fourths of children with ADHD, and other classes of medication (e.g., antidepressants) sometimes help when stimulants are not effective. Other approaches such as cognitive-behavioral therapy have produced mixed results in research studies (Abikoff, 1991), but they may provide supplementary benefit in some cases.

PARENT TRAINING:

Parents of children with ADHD require information about the disorder itself, training in behavior management skills, and emotional support in dealing with the stress engendered by their children's behavioral problems. **The need for specific guided practice in behavior management can be well-served through the format of parent training.** The primary aim of this lesson is to familiarize professionals with the core elements of several prominent models for parent training that are applicable for ADHD children in the preschool through elementary school years. **The parent-training approaches incorporated here are drawn from the programs of Barkley (1987, 1990), Patterson (1976, 1982), and Forehand and McMahon (1981).** Although designed for noncompliant children in general rather than children with ADHD in particular, these programs are highly relevant for the problems with rule-governed behavior (Barkley, 1990) in the ADHD population. The references cited previously **provide clear, detailed instructions for therapists who work with parents of children with ADHD**, and they should be read by professionals who are serious about engaging in this work. These three programs have been outlined and reviewed concisely in a special issue of the *School Psychology Review* on ADHD (Newby, Fischer, & Roman, 1991). This lesson is organized around several core issues in parent training with ADHD, and is not an outline of the separate programs themselves.

Definition and Diagnosis

The definition of ADHD has evolved gradually over the last several decades. The previous term, *minimal brain dysfunction*, was based on the inference that subtle neurological problems were the main cause of the disorder. In the 1960s and 1970s, child psychology and psychiatry reoriented toward diagnostic terms that provided essential descriptions of behavioral syndromes, rather than terms with etiological implications; as a consequence, the labels *hyperactivity* and *hyperkinetic syndrome* became prominent. Research in the 1970s suggested that attentional problems were more ubiquitous and central in the syndrome than motor overactivity itself; therefore, the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) (American

Psychiatric Association, 1980) changed the label to *attention deficit disorder with hyperactivity.* A partial syndrome of attention deficit disorder *without* hyperactivity was also recognized at that time and was presumed to consist of inattention and impulsivity without prominent overactivity. More recently, attention deficit disorder without hyperactivity has been suspected to represent a different class of child psychopathology from ADHD. The diagnostic term was modified slightly to *attention-deficit hyperactivity disorder* in the revision of DSM-III in the late 1980s (DSM-III-R) (American Psychiatric Association, 1987).

Clinicians who conduct parent training for ADHD should be familiar with three definitions of the disorder. It is appropriate to use all three definitions in some combination, both in selecting children who are appropriate for a certain treatment approach and in directly applying specific treatment methods.

DEFINITION I:

Barkley (1990) presented a consensus conceptualization of ADHD that reflects **current accepted clinical theory and research**:

> **Attention deficit hyperactivity disorder is a developmental disorder characterized by developmentally inappropriate degrees of inattention, overactivity, and impulsivity.** These often arise in early childhood; are relatively chronic in nature; and are not readily accounted for on the basis of gross neurological, sensory, language, or motor impairment, mental retardation, or severe emotional disturbance. These difficulties are typically associated with deficits in rule-governed behavior and in maintaining a consistent pattern of work performance over time.

DEFINITION II:

Operational diagnostic criteria for ADHD are necessary in clinical practice. The most commonly accepted diagnostic criteria at present are drawn from DSM-III-R:

- **A disturbance of at least 6 months during which at least eight of the following are present:**
  - Often fidgets with hands or feet or squirms in seat (in adolescents, may be limited to subjective feelings of restlessness)
  - Has difficulty remaining seated when required to do so
  - Is easily distracted by extraneous stimuli
  - Has difficulty awaiting turn in games or group situations
  - Often blurts out answers to questions before they have been completed
  - Has difficulty following through on instructions from others (not due to oppositional behavior or failure of comprehension) (e.g., fails to finish chores)
  - Has difficulty sustaining attention in tasks or play activities
  - Often shifts from one uncompleted activity to another
  - Has difficulty playing quietly
  - Often talks excessively
  - Often interrupts or intrudes on others (e.g., butts into other children's games)
  - Often does not seem to listen to what is being said to him or her
  - Often loses things necessary for tasks or activities at school or at home (e.g., toys, pencils, books, assignments)
  - Often engages in physically dangerous activities without considering possible consequences (not for the purpose of thrill seeking) (e.g., runs into street without looking)

  Note: The above items are listed in descending order of discriminating power based on data from a national field trial of the DSM-III-R criteria for disruptive behavior disorders
- **Onset before age 7**
- **Does not meet the criteria for a pervasive developmental disorder**

In clinical practice, the DSM-III-R criteria are often supplemented with standardized behavior rating questionnaires by parents and teachers. **In order to confirm a diagnosis of ADHD, inattention, impulsivity, and/or hyperactivity scales should show elevations greater than 1½–2 standard deviations above normal population means.** Commonly used questionnaires include the Conners Questionnaire (Conners, 1985) and the Child Behavior Checklist (Achenbach & Edelbrock, 1983, 1986).

DEFINITION III:

A recent reconceptualization of ADHD incorporates **cutting edge theory and research** about the disorder (Barkley, 1990). This type of thinking is highly relevant to parent training models and is likely to influence future operational diagnostic schemes for ADHD:

> **ADHD consists of developmental deficiencies in the regulation and maintenance of behavior by rules and consequences.** These deficiencies give rise to problems with inhibiting, initiating, or sustaining responses to tasks or stimuli, and adhering to rules or instructions, particularly in situations where consequences for such behavior is delayed, weak, or nonexistent. The deficiencies are evident in early childhood and are probably chronic in nature. Although they may improve with neurological maturation, the deficits persist in comparison to same-age normal children, whose performance in these areas also improves with development.

Most parent training programs for ADHD focus on behavior management of children's problems with noncompliance and poor rule-governed behavior. This focus is consistent with the high prevalence of comorbid oppositional-defiant disorder or conduct disorder in the ADHD population. Clinicians should be aware that children with ADHD who also have prominent comorbid internalizing problems, such as anxiety or depressive disorders, may not respond ideally to a behavior management emphasis in parent training. **The multiple problems of these children may be better addressed through individual or family psychotherapy, sometimes supplemented with the type of parent training outlined here.** Similarly, children with ADHD who have reached adolescence usually present complex developmental issues of emerging independence and may not respond favorably to the "top down" management style that is implicit in the behaviorally oriented parent-training approaches described herein. **The needs of families with adolescents with ADHD are probably better addressed through pragmatically oriented family methods that develop both parents' and adolescents' skills in negotiation and conflict resolution**, such as the program of Robin and Foster (1989).

Outline of a Typical Parent-Training Sequence

As noted above, the ideas outlined here are integrated from other original sources. The general recommended treatment sequence and most of the specific content generally follow Barkley (1987), whose written handouts for parents represent excellent supplements to direct verbal instruction and demonstration of methods by the therapist.

DIAGNOSTIC ASSESSMENT:

Any parent-training intervention should be preceded by a careful assessment of the child, family, and environment. Most assessment procedures for ADHD involve some combination of parent interviews, child interviews, clinical observations, observations in naturalistic environments, parent- and teacher-completed behavior rating questionnaires, and/or direct psychological testing.

TREATMENT GOALS:

The primary goals of parent training are: (1) Increasing parents' knowledge of the causes of children's difficult behavior patterns, particularly in terms of relevant research on ADHD and social learning theory; **(2) Improving parents' skills in managing children's behavior problems**; and thereby **(3) increasing children's**

compliance with commands and rules. Several core principles underlie the methods in parent training for ADHD. Among the most prominent of these principles is the importance of delivering **immediate, specific, and consistent consequences to children's positive and negative behaviors.** In addition, a strong emphasis is placed on interrupting what Patterson (1982) terms *coercive interaction* and *coercive escalation*. **In coercive interaction, parents and children vie for control by, for instance, presenting aversive stimuli (e.g., the parent issuing a command, or the child arguing) then withdrawing the aversive stimuli (e.g., the parent not enforcing the command, or the child desisting the protest). In coercive escalation, more aversive stimuli are presented (e.g., the parent yelling and threatening), which lead to negative reinforcement of both noncompliance and aversive interactions.**

TREATMENT FORMAT:

There is considerable flexibility in choosing a treatment format for parent training. Forehand and McMahon (1981) worked with mother-child dyads in the clinic, with repeated demonstrations and guided practice in behavior management methods, often using two cotherapists. This approach represents an intensive, direct intervention into family interactions which facilitates detailed feedback to parents and close monitoring of treatment compliance and progress. The program of Patterson (1982) typically involves six to eight sessions with parents from one family at a time, in a tutorial format with instruction, demonstration of techniques, and action homework assignments. The program of Barkley (1987, 1990) is often, but not necessarily, conducted in a group parent-training format, with approximately eight sessions with a group of parents from five to eight different families. **The group format can provide extremely valuable social support among participants**, many of whom feel socially isolated or even ostracized in their struggles with their children's ADHD behaviors. The group also enhances the program by eliciting spontaneous ideas on child management that are shared among parents and by encouraging treatment compliance as parents are asked to review their homework in the presence of other group members.

BUILDING PARENTS' KNOWLEDGE BASE:

Up to two sessions at the beginning of the parent-training sequence can be devoted to increasing parents' understanding of ADHD, behavioral principles that influence parent-child interactions, and general child development. Details on the first two areas are available in Barkley (1990).

The therapist should present the following information on several aspects of ADHD: definition and diagnosis; commonly associated problems; prevalence; theories about etiology; prognosis; and commonly recommended treatment approaches. **It is often useful to supplement direct discussion of ADHD in treatment sessions with handbooks written in understandable language** (Gordon, 1991).

Parent-child interactions are presented as being determined by many different influences: child and parent factors, environmental factors, and situational consequences. The powerful influence of consequences on children's behavior patterns is emphasized, with particular attention paid to issues such as the importance of immediacy and consistency in behavior management consequences for children with ADHD. Several exercises that may be useful in eliciting parental contributions to this discussion include: **asking them to list reasons why children misbehave; asking them to describe the characteristics of favorable and unfavorable employers for whom they have worked; and eliciting examples of typical sequences of behaviors surrounding commands between parents and children, in order to demonstrate the principles of coercive interactions and coercive escalations.**

Many parents of ADHD children lack knowledge about typical child behavior patterns at different stages of development. This can lead to frustrating, unrealistic expectations on their part regarding behavior control. **Both at the beginning of the parent training sequence and at various relevant points throughout the training, it can be very helpful to educate parents about the degree and type of behavior control that they can expect from normal children in the age range with which they are working at home.**

BUILDING PARENT-CHILD RAPPORT AND ENHANCING PARENTS' ATTENDING SKILLS:

Barkley (1987) begins interactive training with parents by teaching them to practice paying attention to their children's positive behaviors in nondirective one-to-one special play times for 15–20 minutes daily. Parents are instructed to avoid questions and commands during these times, and to increase the variety and frequency of their attention toward their children's positive behaviors. For instance, they can practice joining in play activities chosen by the children, directly watching their children play without distracting thoughts about other matters, narrating the play activities out loud, and avoiding questions and commands.

Although the explicit purpose of this exercise is to **increase parent attending skills**, several other benefits often accrue at this critical junction early in the therapy. First, **parents often rediscover a sense of rapport with their behaviorally difficult children**, because of the frequent positive interactions that they almost invariably experience during the special play times. Second, **children often rediscover a personal sense of pleasure and value in their parents' attention toward them**, which in many families of children with ADHD has become a largely negative, coercive interaction pattern. Third, **parents learn to "turn on" and "turn off" their directive guidance roles**, which increases their discretion and flexibility later in the program when they need to focus their own attention on carefully selected commands; this way, they avoid bombarding their children with an unrealistically high flood of commands. It is often helpful to emphasize to parents that this exercise is more for *them* than for their children, and to predict no particular behavioral benefits from this early step in the parent training process; when faced with such a prediction, they are often pleasantly surprised by changes in the rapport that evolves through the activity.

DELIVERING COMMANDS:

Forehand and McMahon (1981) have provided a particularly cogent analysis of the form of relatively successful parental commands (termed *alpha commands*). **Alpha commands are more specific and direct, involve only one request at a time, and allow the child adequate time to enact the command before presenting other verbalizations. Behavioral parent-training methods emphasize that *consequences* for children's behavior can be the most powerful influences on behavior**; therefore, work on command presentation helps with a secondary—but still very important—influence on behavior (i.e., its antecedents). Barkley (1987) provides a pragmatic list of specific **guidelines for command presentation: (1) Select only those commands that are truly important or that the parent "really means"; (2) phrase the command as a statement rather than a question or favor; (3) obtain the child's attention before delivering the command; and (4) give only one command at a time**. Clinical training and practice in command presentation and/or assignments to practice these methods at home represent an important step in parent training. Parents can benefit from this experience, as they learn that **many behavioral methods *improve* compliance even if they do not *guarantee* it.**

DEVELOPING INFORMAL SOCIAL REINFORCEMENT:

The parent-training programs discussed here vary widely—from emphasizing informal social reinforcement on the one hand, to formal token economy systems on the other. **Because most parents of ADHD children do not take full advantage of their capacity to influence their children's behavior through informal praise and compliments, explicit training in this approach usually makes a significant impact on their success in gaining compliance regardless of the extent and type of formal systems that are employed.** In addition, direct training in social reinforcement increases generalization and maintenance of desired behaviors when formal behavior modification systems are faded, or when the management systems are used inconsistently and/or are discontinued covertly by today's busy families. **Working concertedly on informal social reinforcement before formal systems often helps parents become more willing to exert the vigilant effort that it takes to evolve their everyday interactions with their children toward more adaptive patterns, rather than believing that only contrived, formal methods can have a significant impact.**

In this aspect of the training, **parents must learn how to give praise frequently and immediately** (**with specific information about what is being praised) for partial or small behavioral successes as well as major behavioral goals.** Parents often need to be taught not to include implicit or explicit criticisms in their compliments (e.g., "I'm glad to see that you did a better job cleaning up your room today than yesterday"). **The positive feedback that parents begin to develop during special play times can be expanded by giving them lists of methods for increasing the variety as well as the frequency of their verbal and nonverbal praise. The use of praise can be diversified** and expanded by having parents practice chains of commands interspersed with praise after each compliance, or by using **shaping** (gradually spacing out the timing of attention and praise) to reinforce children for independent play while the parent is occupied in some other activity such as talking on the phone.

TEACHING FORMAL BEHAVIOR MODIFICATION SYSTEMS:

Virtually all parents of ADHD children can obtain modest to dramatic improvement in their children's behavior with token economy systems. **The main advantages of formal systems involves their use of individually meaningful rewards (privileges) that can be delayed while the child accumulates concrete symbols of the rewards (tokens), as well as the attractive element of choice on the child's part (e.g., a menu of privileges on which to spend the tokens).** The variety of techniques available are numerous; pragmatic, detailed outlines are available in Barkley (1987) and Patterson (1982).

Although their exact specifications are beyond the scope of this lesson, five general guidelines are worth emphasizing here. **First, many parents can be convinced that the time and energy necessary to apply consistently a formal behavior modification system is worthwhile if the method is presented as a tool rather than a way of life.** Explicit instruction about starting (with cooperative family meetings) and stopping (through deliberate fading rather than covert progressive disuse) these systems is essential. **Second, some families respond best to an overarching system that includes many target behaviors, chores, and routines, whereas others cope better with more limited, partial systems (e.g., morning routine or mealtime behavior). Third, it is usually recommended that parents "sell" the system to their children** by emphasizing that the system will give them credit for all the helpful things that they do at home, and by starting the system for at least the first week with credits for positive behaviors, then adding debits for negative behaviors later. **Fourth, developmental cognitive considerations would suggest concrete tokens in small numbers for preschool and early elementary school children, versus point charts with larger, richer-appearing numbers for older children. Finally, many families are able to extend the influence of token economy systems to the school setting** by working out a reliable, carefully targeted daily-behavior report card with the child's teacher; the incentives for obtaining positive ratings on the card are applied on the same day as soon as the child comes home from school.

USING TIME-OUT:

All three of the parent training programs detailed here use time-out from social reinforcement as the primary punishment method, but the specifics of the time-out procedures vary. Patterson (1982) advocates a **physical barrier to contain the noncompliant child for a brief period of time** (e.g., placing the child in a closed bathroom for several minutes), whereas Barkley (1987) uses a **time-out chair where the parent remains in close enough physical proximity to the child to enforce a backup if the child violates the expectation that he or she stay in time-out** (e.g., spanking or physically restraining the child if he or she gets out of the chair). The main advantage of the physical barrier is that it precludes continued interactions between the parent and child during time-out, thereby minimizing coercive escalation. The time-out chair has the advantage of being the most popular punishment method in many schools and daycare settings, so children are often familiar with this method.

As with token economy procedures, the specifics of an effective time-out procedure are beyond the scope of this lesson, and the reader is referred to Barkley (1987). However, several **central principles** can be highlighted briefly. **First, the positive methods outlined above must be taught and used extensively before introducing punishment methods such as time-out.** Parents can use their usual, familiar punishment procedures in the meantime, unless they are too severe or abusive. **Second, children with ADHD often present such a high frequency of problematic behaviors that parents should be instructed to pick only one or two target behaviors to punish with time-out at first. Third, the complex time-out procedure must be broken into several steps for parents.** Barkley (1987), for instance, separately considers the issues of how the child gets to the chair, where the chair should be placed, what needs to happen before the child is allowed to leave the chair, and how parents should reinforce the time-out procedure if the child leaves the chair without permission. **Finally, parents need particularly strong support and encouragement from the therapist when first instituting this always-confrontive and often-dramatic procedure.**

Unfortunately, most parents of children with ADHD have tried some version of time-out before entering treatment, usually in ways that undermine its effectiveness. **Mistakes often include talking to the child on the chair, not having effective backups if the child gets out of the chair, using a bedroom full of attractive toys, or using time-out inconsistently.** Many parents confuse the central use of time-out as punishment (i.e., an aversive consequence designed to reduce the frequency or intensity of an undesirable behavior) with other important behavior management methods, such as containment of disruptive behavior or a cooling-off period when the child is upset. These alternative uses might allow the child to choose when to leave time-out, whereas a compliance-oriented time-out procedure would let the parent decide when time-out ends and would require the child to agree to fulfill the target command as soon as he or she leaves time-out. The common parental protest, "I've tried that before, and it doesn't work," must be met by emphasizing that **the method must be used exactly to work successfully**; there is no presumed magic in the mere use of the chair.

MANAGING BEHAVIOR IN PUBLIC PLACES:

Barkley (1987) makes the pragmatic recommendation that **parents apply new behavior management methods in the home setting first, then expand to community settings.** This approach takes advantage of the relative ease of establishing routines at home, and it helps make some of the more basic management skills automatic for parents before venturing into more complex environments in which a high degree of vigilance and anticipation of contingencies is required. Many parents find this step particularly compelling, because their children's behavior becomes especially problematic in public places, often constraining and limiting family activities.

There are three basic steps for managing behavior in public places (Barkley, 1987). **First, parents should establish, teach, and verbally review with their children a small number of key rules for each particular public place.** For instance, the rules for a preschool child with ADHD in a grocery store might consist of "stay by me, don't touch, and walk." **Second, an incentive system needs to be implemented to reward children for following the key rules.** In the grocery store example, the child could receive a token at the end of each aisle for successful performance. **Third, parents should carefully plan a modified time-out procedure to be used in the public place when the child fails to follow the key rules to a major extent.** Many parents are reluctant or embarrassed about the prospect of placing a disruptive, noisy child in time-out in a public place, but they are often encouraged by the marked effectiveness of the method, and by the frequent finding that time-out can have the same impact with a shorter punishment period than at home.

Handling Future Behavioral Problems

Children with ADHD will continue to present new types of behavioral problems as they develop and as situational demands change. It is helpful to teach parents a general model for trouble-shooting future problems. An adaptive **four-step process involves: (1) Observing and specifying the problem behavior in detail; (2) formulating positive alternative behavior(s) that will represent the target of the behavioral intervention; (3) informally and/or formally reinforcing the positive alternative behavior as effectively as possible; and (4) introducing a punishment if the reinforcement approach yields weak or inconsistent results.**

Conclusion

This lesson is intended to provide a general orientation on parent training for children with ADHD, and to offer pragmatic directions for the individual clinician to formulate a program that suits the needs of the client.

The wide variety of principles and methods in parent training for children with ADHD leaves many choices for the individual clinician. The effectiveness of these types of programs has been demonstrated in extensive research with noncompliant children in general, with positive but more limited research in ADHD populations in particular (Pisterman, McGrath, Firestone, Goodman, Webster, & Mallory, 1989). The complex nature of many aspects of these behavior management programs, particularly the formal behavior modification procedures and the nuances of time-out, require study of the original references cited in this lesson.

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QUESTIONS BASED ON THIS LESSON

21. Which of the following behaviors stems directly from ADHD?

A. Obsessively completing one task before undertaking another one

B. Carefully considering consequences before engaging in physically dangerous activities

C. Being abnormally quiet while playing

D. Deliberately ignoring instructions of parents

22. Which of the following statements would the author *not* use as a first line of approach to manage behavior of ADHD children in public places?

A. "You must go straight to your room when we get home."

B. "You can have a piece of candy if you behave in this store."

C. "Sit still and don't scream while riding on the train."

D. "Because you misbehaved, I want you to sit on that bench for the next three minutes."

23. Which of the following statements is correct?

A. Research studies have consistently shown cognitive-behavioral therapy to be the best approach for managing ADHD

B. Handbooks should not be used as a means for improving parents' understanding of ADHD, because, even if written in simple language, the books ultimately confuse parents

C. Parent training offers considerable flexibility in choosing a treatment format

D. At least two treatment sessions at the beginning of the parent-training sequence should be devoted to increasing parents' understanding of ADHD

24. When delivering a command to a child with ADHD, parents should:

A. Phrase the command as a favor—not a statement—so that the child does not become frightened

B. Obtain the child's attention first

C. Structure the command so that two commands are presented simultaneously

D. Issue it regardless of its importance

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